Wisconsin Department of Safety and Professional Services
Division of Policy Development
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**Scott Walker, Governor**
**Dave Ross, Secretary**

# BOARD OF NURSING

**Room 121A, 1400 East Washington Avenue, Madison**
**Contact: Dan Williams (608) 266-2112**
**September 8, 2016**

*Notice: The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a description of actions and deliberation of the Board.*

**8:00 A.M.**

## AGENDA

**CALL TO ORDER – ROLL CALL – OPEN SESSION**

A. **Adoption of the Agenda (1-4)**

B. **Approval of the Minutes of July 14, 2016 (5-9)**

C. **Administrative Matters – Discussion and Consideration**
1) Staff Updates
2) Board Member – Term Expiration Date
   a. Paul Abegglen – 7/1/2019
   b. Jodi Johnson – 7/1/2019
   c. Maria Joseph – 7/1/2013
   d. Sheryl Krause – 7/1/ 2018
   e. Jeffrey Miller – 7/1/2016 *(Reappointed, not yet confirmed)*
   f. Peter Kallio – 7/1/ 2018
   g. Lillian Nolan – 7/1/2019
   h. Luann Skarlupka – 7/1/2017
   i. Cheryl Streeter – 7/1/2017

D. **Education and Examination Matters – Discussion and Consideration**
1) Request for Authorization of Admit Students to a Nursing School
   a. Globe University-Madison East **(10-311)**
2) Education Liaison Verbal Update as to ACEN Action for Herzing University-Madison **(312)**
3) Site Survey Report and NCLEX Plan for Herzing University-Brookfield-Kenosha **(313-338)**

E. **APPEARANCE: Mary Muse, R.N., Wisconsin Department of Corrections – Nursing Within Corrections – Discussion and Consideration (339)**

F. **Prescribing Controlled Substances Guidelines (Act 269) – Discussion and Consideration (340-412)**

G. **Criteria for Approving Courses for Pharmacists Who Administer Drug Products and Devices – Discussion and Consideration (413)**

H. **Legislative and Administrative Rule Matters – Discussion and Consideration**

1) Update on Legislation and Pending or Possible Rulemaking Projects

I. **Speaking Engagement(s), Travel, or Public Relations Request(s) – Discussion and Consideration**

1) Travel Report from National Council of State Boards of Nursing (NCSBN) 2016 Annual Meeting – August 17-19, 2016 – Chicago, IL

J. Information Item(s)

K. Discussion and Consideration of Items Received After Preparation of the Agenda

1) Introductions, Announcements, and Recognition
2) Election of Board Officers
3) Appointment of Board Liaison(s)
4) Informational Item(s)
5) Division of Legal Services and Compliance Matters
6) Education and Examination Matters
7) Credentialing Matters
8) Practice Matters
9) Legislation / Administrative Rule Matters
10) Liaison Report(s)
11) Presentations of Petition(s) for Summary Suspension
12) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
13) Presentation of Final Decision and Order(s)
14) Speaking Engagement(s), Travel, or Public Relations Request(s)

L. Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85 (1)(b), and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85 (1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).**

M. **Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

1) **Attorney Amanda Florek**

*a.* ***Administrative Warnings***

1. 16 NUR 048 (R.J.W.) **(414-415)**
2. 16 NUR 336 (M.L.S.) **(416-417)**

*b.* ***Proposed Stipulations, Final Decisions and Orders***

1. 15 NUR 225 and 15 NUR 642 (L.M.S.) **(418-429)**
2. 15 NUR 291 (G.L.B.) **(430-437)**
3. 15 NUR 456 (A.J.D.) **(438-447)**
4. 15 NUR 592 (E.A.W.) **(448-456)**
5. 16 NUR 001 (A.R.) **(457-464)**
6. 16 NUR 073 (S.K.M.) **(465-474)**
7. 16 NUR 077 (W.L.W.) **(475-480)**
8. 16 NUR 108 (M.S.D.) **(481-486)**
9. 16 NUR 119 (S.C.M.) **(487-493)**

2) **Attorney Kim Kluck**

*a.* ***Administrative Warnings***

1. 15 NUR 385 (S.L.K.) **(494-495)**
2. 16 NUR 182 (C.M.B.) **(496-497)**
3. 16 NUR 255 (K.L.S.) **(498-499)**

*b.* ***Proposed Stipulations, Final Decisions and Orders***

1. 15 NUR 201 (S.A.C.) **(500-505)**
2. 15 NUR 485 (H.J.E.) **(506-516)**
3. 15 NUR 703 (A.R.J.) **(517-523)**
4. 15 NUR 703 (L.L.W.) **(524-530)**
5. 16 NUR 040 (J.A.D.) **(531-537)**
6. 16 NUR 172 (T.C.A.) **(538-544)**
7. 16 NUR 173 (A.S.A.) **(545-553)**
8. 16 NUR 259 (B.L.I.) **(554-559)**
9. 16 NUR 289 (T.L.V.P.) **(560-567)**
10. 16 NUR 306 (M.A.M.) **(568-573)**

3) **Case Closures**

4) **Monitoring (574-802)**

a. Sandra Graham, R.N. – Ability to Count Narcotics, Reduction in Drug and Alcohol Screens and AA/NA Meetings **(576-602)**

b. Michelle Gruenewald, R.N. – Reduction in Drug Screens **(603-612)**

c. Angela Hanaman, R.N. – Full Licensure or Reduction in Drug and Alcohol Screens **(613-629)**

d. Tracy Hoeppner, R.N. – Full Licensure or Several Modifications **(630-654)**

e. Jacob Kummer – Review Fitness to Practice Evaluation **(655-674)**

f. Stacey Medved, R.N. – Termination of Treatment and AA/NA Meetings, Reduction in Drug and Alcohol Screens **(675-700)**

g. Gold Omereonye, R.N. – Full Licensure **(701-717)**

h. Heather Pierce, R.N. – Reduction in Drug and Alcohol Screens **(718-738)**

i. Jessica Placek, R.N. – Reduction in Drug and Alcohol Screens **(739-765)**

j. Paula Salkin, R.N. – Termination of Home Health, Agency, and Direct Supervision Restrictions **(766-780)**

k. Carrie Skifstad – Stay of Suspension and Termination of Treatment **(781-802)**

N. **Deliberation on Credentialing Matters**

1) Audrey Doro – Licensed Practical Nurse Application **(803-844)**
2) Paige Engle - Licensed Practical Nurse Application **(845-853)**
3) Beverly Kerkstra - Licensed Practical Nurse Application **(854-861)**
4) RaeLene Mace – Registered Nurse Application **(862-875)**

O. **Deliberation on Order(s) Fixing Costs in the Matter of Disciplinary Proceedings Against:**

1) Jana L. Blair, R.N., Respondent (ORDER0004804)(DHA Case # SPS-16-0029)(DLSC Case # 15 NUR 416) **(876-882)**
2) Nickea C. Connolly, R.N., Respondent (ORDER0004805)(DHA Case # SPS-16-0015)(DLSC Case # 15 NUR 562) **(883-888)**
3) Amber Lichtwalt, R.N., Respondent (ORDER0004766)(DHA Case # SPS-16-0018)(DLSC Case # 14 NUR 618) **(889-896)**
4) Sarah A. Trebbe, R.N., Respondent (ORDER0004810)(DHA Case # SPS-16-0025)(DLSC Case # 15 NUR 115) **(897-902)**

P. Deliberation of Items Received After Preparation of the Agenda

1) Professional Assistance Procedure (PAP) Matters
2) Division of Legal Services and Compliance Matters
3) Monitoring Matters
4) Credentialing Matters
5) Education and Examination Matters
6) Administrative Warnings
7) Review of Administrative Warnings
8) Proposed Stipulations, Final Decisions and Orders
9) Proposed Final Decisions and Orders
10) Orders Fixing Costs/Matters Related to Costs
11) Petitions for Summary Suspension
12) Petitions for Designation of Hearing Examiner
13) Petitions for Re-hearings
14) Appearances from Requests Received or Renewed
15) Motions

Q. Consult with Legal Counsel

**RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

Voting on Items Considered or Deliberated on in Closed Session, If Voting is Appropriate

R. **Board Meeting Process (Time Allocation, Agenda Items) – Discussion and Consideration**

1) **Newsletter**
   a. **September 2016 Newsletter Draft for Board Approval**

S. Board Strategic Planning and its Mission, Vision, and Values – Discussion and Consideration

**ADJOURNMENT**

The next scheduled meeting is October 13, 2016.

**BOARD OF NURSING**
**MEETING MINUTES**
**JULY 14, 2016**

**PRESENT:** Paul Abegglen, Peter Kallio, Jodi Johnson, Maria Joseph, Sheryl Krause *(was excused from the meeting at 9:57 a.m. and rejoined the meeting at 11:59 a.m.)*, Jeffrey Miller, Lillian Nolan, Luann Skarlupka, Cheryl Streeter

**STAFF:** Dan Williams, Executive Director; Nilajah Hardin, Bureau Assistant; and other DSPS Staff

## CALL TO ORDER

Jeffrey Miller called the meeting to order at 9:04 a.m. A quorum of nine (9) members was confirmed.

## ADOPTION OF THE AGENDA

**Amendments to the Agenda**

- *Item B is corrected to read "Approval of Minutes of June 9, 2016"*

**MOTION:** Luann Skarlupka moved, seconded by Jodi Johnson, to adopt the agenda as amended. Motion carried unanimously.

## APPROVAL OF MINUTES OF JUNE 9, 2016

**MOTION:** Luann Skarlupka moved, seconded by Peter Kallio, to approve the minutes of June 9, 2016 as published. Motion carried unanimously.

## LEGISLATIVE AND ADMINISTRATIVE RULE MATTERS

**Adopt Clearinghouse Rule 15-067 Relating to Grounds for Denial**

**MOTION**: Luann Skarlupka moved, seconded by Cheryl Streeter, to approve the Adoption Order for Clearinghouse Rule 15-067 Relating to Grounds for Denial. Motion carried unanimously.

**Adopt Clearinghouse Rule 15-099 Relating to Renewal and Standards of Practice**

**MOTION**: Luann Skarlupka moved, seconded by Cheryl Streeter, to approve the Adoption Order for Clearinghouse Rule 15-099 Relating to Renewal and Standards of Practice. Motion carried unanimously.

**Adopt Clearinghouse Rule 16-020 Relating to Advance Practice Nurse Prescribers**

**MOTION**: Luann Skarlupka moved, seconded by Cheryl Streeter, to approve the Adoption Order for Clearinghouse Rule 16-020 Relating to Advance Practice Nurse Prescribers. Motion carried unanimously.

DRAFT

**Proposals for Repealing N 3 Relating to Examining Councils**

**MOTION**: Peter Kallio moved, seconded by Luann Skarlupka, to approve the preliminary rule draft of N 3 relating to Examining Councils for posting of economic impact comments and submission to the Clearinghouse. Motion carried unanimously.

## SPEAKING ENGAGEMENT(S), TRAVEL, OR PUBLIC RELATIONS REQUEST(S)

**Hospital to Hospital (H2H) Meeting – July 22, 2016 – Ladysmith, WI**

**MOTION:** Lillian Nolan moved, seconded by Peter Kallio, to designate Jeffrey Miller to speak on the Board's behalf at the Hospital to Hospital (H2H) Meeting on July 22, 2016 in Ladysmith, WI and to authorize travel. Motion carried unanimously.

**National Council of State Boards of Nursing (NCSBN) 2016 NCLEX Conference – September 12, 2016 – Philadelphia, PA**

**MOTION:** Cheryl Streeter moved, seconded by Lillian Nolan, to designate Sheryl Krause, as the Board's delegate, to attend the National Council of State Boards of Nursing (NCSBN) 2016 NCLEX Conference on September 12, 2016 in Philadelphia, PA and to authorize travel. Motion carried unanimously.

## ITEMS RECEIVED AFTER PREPARATION OF THE AGENDA

**MOTION:** Lillian Nolan moved, seconded by Luann Skarlupka, to designate Sheryl Krause, Jeffrey Miller, and Paul Abegglen, as the Board's delegate, to attend the National Council of State Boards of Nursing (NCSBN) 2016 Scientific Symposium on October 6, 2016 in Chicago, IL and to authorize travel. Motion carried unanimously.

*Sheryl Krause was excused from the meeting at 9:57 a.m.*

## CLOSED SESSION

**MOTION:** Luann moved, seconded by Jodi Johnson, to convene to closed session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85 (1)(b), Stats.); to consider closing disciplinary investigation with administrative warning (ss.19.85(1)(b), Stats. and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85 (1)(f), Stats.); and, to confer with legal counsel (s.19.85(1)(g), Stats.). Jeffrey Miller, Chair, read the language of the motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Paul Abegglen-yes; Jodi Johnson-yes; Maria Joseph-yes; Peter Kallio-yes; Jeffrey Miller-yes; Lillian Nolan-yes; Luann Skarlupka-yes; and Cheryl Streeter-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:58 a.m.

## RECONVENE TO OPEN SESSION

**MOTION:** Luann Skarlupka moved, seconded by Peter Kallio, to reconvene into open session. Motion carried unanimously.



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The Board reconvened into Open Session at 11:48 a.m.

## VOTING ON ITEMS CONSIDERED OR DELIBERATED ON IN CLOSED SESSION

**MOTION:** Cheryl Streeter moved, seconded by Jodi Johnson, to affirm all motions made in closed session. Motion carried unanimously.

## DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

**DLSC Attorney Kim Kluck**

***Administrative Warnings***

**MOTION:** Cheryl Streeter moved, seconded by Peter Kallio, to issue an Administrative Warning in the following matters:

1. 16 NUR 005 (K.P.A.)
2. 16 NUR 064 (J.R.B.)
3. 16 NUR 101 (J.E.A.)
4. 16 NUR 295 (W.M.Y.)

Motion carried unanimously.

***Proposed Stipulations, Final Decisions and Orders***

***16 NUR 273 – M.L.W.***

**MOTION:** Peter Kallio moved, seconded by Maria Joseph, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Mary L. Wegner, L.P.N., DLSC case number 16 NUR 273. Motion carried unanimously.

**Attorney Amanda Florek**

***Proposed Stipulations, Final Decisions and Orders***

**MOTION:** Cheryl Streeter moved, seconded by Paul Abegglen, to accept the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against:

1. 15 NUR 378 and 15 NUR 439 (T.L.H.)
2. 15 NUR 599 (J.M.S.)
3. 16 NUR 091 (E.S.J.)

Motion carried unanimously.

***Proposed Stipulations, Final Decisions and Remedial Education Orders***

***15 NUR 661 – J.R.***

**MOTION:** Paul Abegglen moved, seconded by Maria Joseph, to adopt the Findings of Fact, Conclusions of Law and Remedial Education Order in the matter of disciplinary proceedings against Jennifer Rucker, R.N., DLSC case number 15 NUR 661. Motion carried unanimously.

DRAFT

**Monitoring**

***Cassandra Conrath Bellin, R.N. – Reduction in Drug and Alcohol Screens***

**MOTION:** Jodi Johnson moved, seconded by Cheryl Streeter, to deny the request of Cassandra Conrath Bellin, R.N. for a reduction in drug and alcohol screens. **Reason for Denial**: Failure to demonstrate continuous and successful compliance. Respondent needs to fully comply with the complete terms and conditions of the original Board Order (01/26/2012). Respondent may petition the Board again after six months of full compliance. Motion carried unanimously.

***Julie Harley, L.P.N. – Reduction in Drug and Alcohol Screens***

**MOTION:** Lillian Nolan moved, seconded by Jodi Johnson, The Board takes no action on this request. Pursuant to the Board Order (12/19/2013), Respondent may only petition the Board on an annual basis (January 2017). The Board will not consider a request for modification until Respondent shows full compliance with the Order during the period of May 2016-January 2017. Motion carried unanimously.

***Ross Huber, R.N. – Reduction in Drug and Alcohol Screens***

**MOTION:** Jodi Johnson moved, seconded by Cheryl Streeter, to grant the request of Ross Huber, R.N. for a reduction in drug and alcohol screens to 36 per year and one annual hair test. Motion carried unanimously.

***Patricia Pokallus, R.N. – Reduction in Screens, Access to Controlled Substances, and Job Approval***

**MOTION:** Lillian Nolan moved, seconded by Cheryl Streeter, to grant the request of Patricia Pokallus, R.N. for a reduction in drug and alcohol screens to 36 per year, approval of the Hospital Transfer/Transport Triage position at Marshfield Clinic. The Board denies the request of Patricia Pokallus, R.N. for access to controlled substances. **Reason for Denial**: Insufficient time of compliance under the terms of the Order (05/09/2013). Motion carried unanimously.

***Kathleen Preston, L.P.N. – Full Licensure***

**MOTION:** Luann Skarlupka moved, seconded by Maria Joseph, to grant the request of Kathleen Preston, L.P.N. for full licensure. Motion carried unanimously.

***Angela Subjek, R.N. – Reduction in Screens***

**MOTION:** Peter Kallio moved, seconded by Cheryl Streeter, to grant the request of Angela Subjek, R.N. for a reduction in drug screens to 28 per year and one annual hair test. Motion carried unanimously.

DRAFT

## PROPOSED FINAL DECISION(S) AND ORDER(S)

**Jana L. Blair, R.N., Respondent (DHA Case # SPS-16-0029)(DLSC Case # 15 NUR 416)**

**MOTION:** Luann Skarlupka moved, seconded by Paul Abegglen, to adopt the Findings of Fact, Conclusions of Law, and Proposed Decision and Order in the matter of disciplinary proceedings against Jana L. Blair, R.N., Respondent (DHA Case # SPS-16-0029)(DLSC Case # 15 NUR 416). Motion carried. Recused: Jodi Johnson

*(Jodi Johnson recused herself and left the room for deliberation, and voting in the matter concerning Jana L. Blair, R.N., Respondent (DHA Case # SPS-16-0029)(DLSC Case # 15 NUR 416).)*

**Nickea C. Connolly, R.N., Respondent (DHA Case # SPS-16-0015)(DLSC Case # 15 NUR 562)**

**MOTION:** Peter Kallio moved, seconded by Cheryl Streeter, to adopt the Findings of Fact, Conclusions of Law, and Proposed Decision and Order in the matter of disciplinary proceedings against Nickea C. Connolly, R.N., Respondent (DHA Case # SPS-16-0015)(DLSC Case # 15 NUR 562). Motion carried. Recused: Lillian Nolan

*(Lillian Nolan recused herself and left the room for deliberation, and voting in the matter concerning Nickea C. Connolly, R.N., Respondent (DHA Case # SPS-16-0015)(DLSC Case # 15 NUR 562).)*

**Sarah A. Trebbe, R.N., Respondent (DHA Case # SPS-16-0025)(DLSC Case # 15 NUR 115)**

**MOTION:** Jodi Johnson moved, seconded by Maria Joseph, to adopt the Findings of Fact, Conclusions of Law, and Proposed Decision and Order in the matter of disciplinary proceedings against Sarah A. Trebbe, R.N., Respondent (DHA Case # SPS-16-0025)(DLSC Case # 15 NUR 115). Motion carried. Recused: Luann Skarlupka

*(Luann Skarlupka recused himself and left the room for deliberation, and voting in the matter concerning Sarah A. Trebbe, R.N., Respondent (DHA Case # SPS-16-0025)(DLSC Case # 15 NUR 115).)*

*Sheryl Krause rejoined the meeting at 11:59 a.m.*

## ADJOURNMENT

**MOTION:** Cheryl Streeter moved, seconded by Peter Kallio, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:03 p.m.

DRAFT

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| | |
|---|---|
| 1) Name and Title of Person Submitting the Request:<br><br>**Dan Williams** | 2) Date When Request Submitted:<br><br>Items will be considered late if submitted after 4:30 p.m. and less than:<br>▪ 10 work days before the meeting for Medical Board<br>▪ 14 work days before the meeting for all others |

3) Name of Board, Committee, Council, Sections:

**Wisconsin Board of Nursing**

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **September 8, 2016** | ☐ Yes<br>☐ No | **Globe University – Madison East, Authorization to Admit request_Discussion and Consideration** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☐ Yes by<br>☒ No | N/A |

10) Describe the issue and action that should be addressed:

See attachments.

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
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**BOARD OF NURSING**

REQUEST FOR AUTHORIZATION TO ADMIT STUDENTS TO A NURSING SCHOOL

After authorization to plan a nursing school is granted by the Board of Nursing to an institution, the institution must submit a request to the Board for authorization to admit students to the nursing school; the application must include all of the following:

(1) Verification of employment of an educational administrator meeting the qualifications in N 1.08 (2) including the following:
- Current, active registered nurse license or privilege to practice in Wisconsin that is not encumbered
- Graduate degree with a major in nursing
- Knowledge of learning principles for adult education, including nursing curriculum development, administration and evaluation and either educational preparation or 2 years experience as an instructor in a nursing education program within the last 5 years
- Current knowledge of nursing practice

(2) Evidence of faculty meeting the qualifications in N 1.08(3) including the following:

A) For Professional Nursing Faculty:
- Current, active registered nurse license or privilege to practice in Wisconsin that is not encumbered
- Graduate degree with a major in nursing; interprofessional faculty teaching non-clinical nursing courses must have advanced preparation appropriate for the content being taught.

B) For Practical Nursing Faculty:
- Current, active registered nurse license or privilege to practice in Wisconsin that is not encumbered.
- Baccalaureate degree with a major in nursing.

(3) School's philosophy and objectives

(4) Overview of curriculum including all of the following:
- Content
- Course sequence
- Course descriptions
- Program evaluation plan
- Course syllabi for the first year and plan for subsequent years

(5) Verification of establishment of student policies for admission, progression, retention and graduation

(6) Updated timeline for implementing the program and intended date for entry of the first class


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(7) Verification of students' ability to acquire clinical skills by providing all of the following:

- Letter of intent or contracts from clinical facilities securing clinical opportunities and documentation of the facility type, size, number of beds, and type of patients.
- Documentation of simulation equipment and experiences.

The Board will make a decision on the application to admit students within two months of receipt of the completed application and notify the institution of the action taken on the application. Once a school receives authorization to admit, the school may begin admitting students while seeking to obtain program approval.

Withdrawal of authorization may occur if the school fails to meet and maintain standards in N 1.08.

**To apply for authorization to admit students, submit the following required items to dspsexaminationsoffice@wisconsin.gov:**

(1) Form #1114 for each faculty member and for the program educational administrator

(2) A written proposal addressing items three (3), four (4), five (5) and six (6) above.

(3) Form #1004 for each clinical facility

**Institution applying for authorization to admit students:**

Name of School: _Globe University - Madison East _____

Address: 4901 Eastpark Blvd._____

_Madison, WI 53718_____

Nursing Program(s) (ADN, BSN, Other): __BSN, RN to BSN Completion Program_____

Kendra K. Saal
Nursing Educational Administrator

Dean of Nursing
Title

Kendra K Saal
Signature

6.20.16
Date

612-455-4781
Telephone Number

Ksaal@msbcollege.edu
Email Address

1. Verification of employment of an education administer meeting the qualifications in N 1.08 (2).
    a. See Form #1114 (Attachment A)
2. Evidence of faculty meeting the qualifications in N 1.08 (3):
    a. See Form #1114 (Attachment B)
3. Schools philosophy and objectives
    a. Philosophy: Globe University/ Minnesota School of Business recognizes the dynamics between personal and professional development. We therefore invest in our students by providing knowledge and skills to support their immediate employment goals and credentials and provide foundations for career opportunities. Further, we acknowledge human resources as a central driver of business and prosperous communities. Education increases citizens' quality of life and ability to contribute to these communities.

        We subscribe to the principles of affirmative action and do not discriminate in admission or employment based on race, creed, ethnic origin, nationality, religion, gender, sexual orientation, physical or mental disability, or veteran status. In addition, the institution respects the dignity of each individual, an essential condition to the learning environment.

    b. Objectives:

| WE CARE ABOUT | WE ARE COMMITTED TO |
|---|---|
| Student Success | Attracting students and delivering relevant, quality educational experiences that engage students and lead them to graduation and career success. |
| Employee Success | A dynamic environment that recognizes performance and provides growth opportunities. |
| Investment Success | Providing a quality education that leads to a strong return on investment for all stakeholders. |
| Customer Service | Being the premier provider of career education by exceeding the expectations of our Students, Employers, and Employees. |
| Communication | Engaging in and managing effective communication. |
| Compliance | Maintaining a culture of compliance. |
| Community Engagement | Building communities through education. |

    c. Vision: We Care about our Students, We Care about our Employees, and We Care about the Employers who hire our Students.
    d. Mission: We will demonstrate We Care by preparing career-focused, community-minded graduates for the global workforce.
4. Overview of curriculum:
    a. See Attachment C
5. Verification of establishment of student policies for admission, progression, retention and graduation.
    a. See Attachment D
6. Updated timeline for implementing the program and intended date for entry of the first class.

   a. Projected start of first class would be Winter 2017 (January 2, 2017)
7. Verification of students' ability to acquire clinical skills:
   a. See Form #1004 for clinical facilities (Attachment E)

# Wisconsin Department of Safety and Professional Services

**Mail To: P.O. Box 8366** 1400 E. Washington Avenue
**Madison, WI 53708-8366** Madison, WI 53703
FAX #: (608) 266-2602 E-Mail: dsps@wisconsin.gov
**Phone #: (608) 266-2112** Website: dsps.wisconsin.gov

**BOARD OF NURSING**

FACULTY / EDUCATIONAL ADMINISTRATOR QUALIFICATION RECORD

**New nursing school seeking authorization to admit students:** Completion of this form is required for each faculty member and the educational administrator. This form must be submitted to the Board of Nursing along with the request for authorization to admit students.

**Nursing school approved by the Board of Nursing:** Completion of this form is required for each faculty member and the educational administrator. The form must be kept on file in the school of nursing office and made available to the Board upon request for all faculty members and educational administrators hired by the nursing school.

**Change in educational administrator:** Institutions are required to notify the Board of Nursing within 48 hours of the termination resignation or retirement of an educational administrator and designate an interim educational administrator (EA) within five (5) business days. Completion and submission of this form is required as part of the notification process.

Faculty/EA Name (*Last, First*): Saal, Kendra WI RN License #: 226239 – 30

School of Nursing Employed By: Globe University

Type of Nursing Program(s) (ADN, PN, BSN, etc.): BSN

Position: X Educational Administrator _____ Faculty

Appointment Effective Date: Effective immediately

## FACULTY APPOINTMENTS (complete Section A below).

Fully-qualified faculty must have a current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered and a graduate degree with a major in nursing.

### A. EDUCATIONAL PREPARATION

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |



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# Wisconsin Department of Safety and Professional Services

## EDUCATIONAL ADMINISTRATOR APPOINTMENTS

Fully-qualified educational administrator must have current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered, a graduate degree with a major in nursing, knowledge of learning principles for adult education, including nursing curriculum development, administration and evaluation, current knowledge of nursing practice and **either** educational preparation (master's degree in nurse education or doctorate degree in nurse education) or at least tw (2) years experience as an instructor in a nursing education program within the last five (5) years.

**NOTE:** Applicant must complete Section A below; complete Section B below only if teaching experience is being applied toward the requirements in lieu of an earned master's or doctorate degree in nurse education.

List most recent education preparation and teaching experience first. Attach additional pages as necessary.

### A. EDUCATIONAL PREPARATION

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
|---|---|---|---|---|---|
| Lakeview College of Nursing | Danville, IL | 12/2006 | BSN | Nursing | |
| University of Phoenix | Online | 09/2009 | MSN | Nursing Education | |
| | | | | | |

### B. NURSING INSTRUCTION EXPERIENCE*

***Complete this section only if a master's or doctorate degree in nurse education has not been earned and teaching experience is being applied in lieu of a master's or doctorate degree in nursing.**

| From Month/Year | To Month/Year | Part-time or Full-time | Location City/State | Position/Job Title |
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Kendra K. Saal
Educational Administrator

Dean of Nursing
Title

Kendra K. Saal
Signature

03/25/2016
Date

612.455.4781
Telephone Number

ksaal@globeuniversity.edu
Email Address

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## FACULTY / EDUCATIONAL ADMINISTRATOR QUALIFICATION RECORD

**New nursing school seeking authorization to admit students:** Completion of this form is required for each faculty member and the educational administrator. This form must be submitted to the Board of Nursing along with the request for authorization to admit students.

**Nursing school approved by the Board of Nursing:** Completion of this form is required for each faculty member and the educational administrator. The form must be kept on file in the school of nursing office and made available to the Board upon request for all faculty members and educational administrators hired by the nursing school.

**Change in educational administrator:** Institutions are required to notify the Board of Nursing within 48 hours of the termination, resignation or retirement of an educational administrator and designate an interim educational administrator (EA) within five (5) business days. Completion and submission of this form is required as part of the notification process.

Faculty/EA Name (*Last, First*): Olson, Susan WI RN License #: 66173-30

School of Nursing Employed By: Globe University

Type of Nursing Program(s) (ADN, PN, BSN, etc.): BSN

Position: X Educational Administrator ____ Faculty

Appointment Effective Date: 03/28/2016

## FACULTY APPOINTMENTS (complete Section A below).

Fully-qualified faculty must have a current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered and a graduate degree with a major in nursing.

### A. EDUCATIONAL PREPARATION

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
|---|---|---|---|---|---|
| Edgewood | Madison, WI | 2008 | MSN | Nursing | Education |
| UW Madison | Madison, WI | 2003 | BSN | Nursing | |
| Madison General | Madison | 1976 | Diploma | Nursing | |
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Committed to Equal Opportunity in Employment and Licensing

# Wisconsin Department of Safety and Professional Services

## EDUCATIONAL ADMINISTRATOR APPOINTMENTS

Fully-qualified educational administrator must have current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered, a graduate degree with a major in nursing, knowledge of learning principles for adult education, including nursing curriculum development, administration and evaluation, current knowledge of nursing practice, and **either** educational preparation (master's degree in nurse education or doctorate degree in nurse education) or at least two (2) years experience as an instructor in a nursing education program within the last five (5) years.

**NOTE:** Applicant must complete Section A below; complete Section B below only if teaching experience is being applied toward the requirements in lieu of an earned master's or doctorate degree in nurse education.

List most recent education preparation and teaching experience first. Attach additional pages as necessary.

**A. EDUCATIONAL PREPARATION**

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
|---|---|---|---|---|---|
| Edgewood | Madison | 2008 | Master in | Nursing | Education |
| University of WI | Madison | 2003 | BSN | Nursing | |
| Madison General | Madison | 1976 | Diploma | Nursing | |
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**B. NURSING INSTRUCTION EXPERIENCE***

***Complete this section only if a master's or doctorate degree in nurse education has not been earned and teaching experience is being applied in lieu of a master's or doctorate degree in nursing.**

| From Month/Year | To Month/Year | Part-time or Full-Time | Employer/School | Location City/State | Position/Job Title |
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Susan K. Olson
Educational Administrator

Instructor & Program Chair
Title

Susan K. Olson RN
Signature

3/20/2016
Date

(608) 216-9465
Telephone Number

susanolson@globeuniversity.edu
Email Address

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
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1400 E. Washington Avenue
Madison, WI 53703
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## BOARD OF NURSING

FACULTY / EDUCATIONAL ADMINISTRATOR QUALIFICATION RECORD

**New nursing school seeking authorization to admit students:** Completion of this form is required for each faculty member and the educational administrator. This form must be submitted to the Board of Nursing along with the request for authorization to admit students.

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**Change in educational administrator:** Institutions are required to notify the Board of Nursing within 48 hours of the termination, resignation or retirement of an educational administrator and designate an interim educational administrator (EA) within five (5) business days. Completion and submission of this form is required as part of the notification process.

Faculty/EA Name (*Last, First*): Cordova, Rita WI RN License #: 89338-30

School of Nursing Employed By: Globe University

Type of Nursing Program(s) (ADN, PN, BSN, etc.): BSN

Position: Educational Administrator X Faculty ____

Appointment Effective Date: Currently teaches in Medical Assistant program

## FACULTY APPOINTMENTS (complete Section A below).

Fully-qualified faculty must have a current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered and a graduate degree with a major in nursing.

### A. EDUCATIONAL PREPARATION

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
|---|---|---|---|---|---|
| Edgewood College | Madison, WI | 1/10/2006 | M.S. | Nursing | |
| Lenoir-Rhyne University | Hickory, NC | 5/8/1983 | B.S. | Nursing | |
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Committed to Equal Opportunity in Employment and Licensing

# Wisconsin Department of Safety and Professional Services

## EDUCATIONAL ADMINISTRATOR APPOINTMENTS

Fully-qualified educational administrator must have current, active Registered Nurse license or privilege to practice in Wisconsin that is not encumbered, a graduate degree with a major in nursing, knowledge of learning principles for adult education, including nursing curriculum development, administration and evaluation, current knowledge of nursing practice, and **either** educational preparation (master's degree in nurse education or doctorate degree in nurse education) or at least two (2) years experience as an instructor in a nursing education program within the last five (5) years.

**NOTE:** Applicant must complete Section A below; complete Section B below only if teaching experience is being applied toward the requirements in lieu of an earned master's or doctorate degree in nurse education.

List most recent education preparation and teaching experience first. Attach additional pages as necessary.

### A. EDUCATIONAL PREPARATION

| Name of Institution | Location City/State | Graduation Date | Degree Earned or # of Credits | Major | Minor |
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### B. NURSING INSTRUCTION EXPERIENCE*

***Complete this section only if a master's or doctorate degree in nurse education has not been earned and teaching experience is being applied in lieu of a master's or doctorate degree in nursing.**

| From Month/Year | To Month/Year | Part-time or Full-Time | Employer/School | Location City/State | Position/Job Title |
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**Kendra Saal**
Educational Administrator

Kendra Saal
Signature

612-455-4781
Telephone Number

**Dean of Nursing**
Title

8/25/2016
Date

ksaal@msbcollege.edu
Email Address

**Rita Cordova RN, MSN**
305 7th St.
Waunakee WI, 53597

**Curriculum Vitae**

## Education

**Master of Science Nursing Administration January 2006**
Edgewood College, Madison,WI

**Bachelor of Science in Nursing May 1983**
Lenoir Rhyne College, Hickory NC

**CMA (AAMA), ASMA**
Kaiser University, Fort Lauderdale, FL

## Professional Experience

**Trinity Senior Communities, Oct. 15 to Present**
Direct resident care for 48 residents in Assisted Living environment. Develop care plans for residents and provide supervision and education for the Resident Assistants and other staff to provide quality and individualized care.

**Program Chair of Medical Assisting, July 2014 to September 2015**
**Adjunct Instructor Medical Assisting September 2015 to Present**

*Globe University West- Madison, WI*
Responsibilities included organizing and coordinating the ABHES Reaccreditation Visit for the Campus. The ABHES Accreditation visit was cite free. Supervising MA Faculty, evaluating and facilitating program improvements including teaching faculty about using Blackboard technology. Teaching Medical Assisting courses. Coordinating externships.

Courses taught at Globe University:
MA 212 Microbiology and Urinalysis
MA 131 Introduction to Clinical Skills
MA 149 Patient Care I
MA 174 Introduction to Administration
MA 286 Program Review
MA 272 Clinical Externship
MA 223 Hematology
MA 205 Essential Lab Skills and Procedures
NS 140 Anatomy and Physiology I. This is a Part 1 course for Nursing, Medical Assisting, Massage Therapy, and Exercise Physiology majors.

Accompanied students to mid- year conventions 2011 and 2012
Mid- year convention 2011 Memphis, TN
Midyear convention 2012 San Diego, CA

**Staff Development Coordinator April 2006 to August 2008**
Middleton Village Madison WI
Responsible for the supervision and education of CNA's, LPN's, and RN staff. Infection Control monitoring

## Professional Affiliations & Organizations

**National Student Nurses Association**
2012 to 2014

**National League for Nursing (NLN)**
2008 to 2014

## Awards and Recognitions

Faculty of the Year Globe University Madison West 2014

Lead Facilitator of ABHES 5 year Re-Accreditation Visit Globe Madison West- 0 citations

National Student Nurses Association (NSNA)
Consultant and Advisors Certificate November 2012

Key Note Speaker Herzing University Madison Campus Nurse Pinning Ceremony June 2012

Madison Campus Faculty Service Award 2011

## Community and Volunteer Activity

**City on a Hill Milwaukee, WI, Free Clinic 2010 to present**
Volunteer as an RN at a free clinic bringing MA and RN students as Volunteers . Services included B/P screening, blood glucose monitoring, foot care, and health education.

**Touched Twice Clinic Free Clinic Madison WI, 2011 to present**
Volunteered as an RN on the planning committee for the Madison Touched Twice Clinic. Volunteer biannually bringing MA and RN students as Volunteers. Services included B/P screening, blood glucose monitoring, ht. and wt. measurements, rooming and assisting physicians, and providing health education

**River Food Pantry Madison WI, 2011**
Volunteered as an RN bringing MA and RN students as Volunteers. Services included providing blood glucose screening, B/P screening, Nutritional and health education.

**Reality Maze Rock County Outreach Program 2012 to present**
Franklin Middle School February 2012 and April 2013 next Reality Maze to be in September 2013

RN students participated in providing education for 8th grade students via demonstrations, videos, props and case scenarios the consequences of risky behaviors including drug and alcohol abuse, teen pregnancy, and texting while driving. Organizations in Rock County also participating in this program included the Rock County Police, Juvenile Detention, EMS, Lawyers from the legal system and counselors.

**Goodman Center Madison WI December 2012 to Present**
December 2012 Senior Christmas Party- Volunteered to serve meals and dance with Senior Citizens along with other faculty members.

**April 2013 Preschool Program-** RN students gave presentations to the children on handwashing and healthy snacks.

**Food for Kidz 2011 and 2012**
Coordinate and participate having Herzing University students and Globe University assist with packaging meals for families in need. Event held annually in Waunakee WI.

**FAST 2013 to present**
Functional Assessment Service Teams. Attended two day disaster training.

**July 2014 Preschool Program-** Medical Assisting students gave presentations to the children on handwashing and spreading germs.

**WEAVR Member 2014 to present**
Wisconsin Emergency Assistance Volunteer Registry. Registered to assist as a Registered Nurse in a disaster situation.
Attended SURGE X Disaster Training as a FAST Team Member May 2014 and May 2015

**Helping Hands Medical Mission Nurse Team Member Atoes, El Salvador**
March 2015
March 2016

**Reviewer for Medical Assisting Textbook**

Michelle Blesi, Barbara Wise, Cathy Kelley-Arney, (2012). *Medical Assisting Administrative and Clinical Competencies, (7th* ed.). Clifton Park, NY: Delmar, Cengage Learning

**Rita M. Cordova, RN, MSN**
**305 7th Street**
**Waunakee, WI. 53597**
**(608) 516-1208**
**E-mail address: cordovarm1217@gmail.com**

**July 14 to Present** **Globe University, 1345 Deming Way, Middleton WI 53562**
Academic Chair Medical Assisting Program July 2014 to December 2015. Lead the Globe Madison in the American Bureau Of Health Services Accreditation visit in October 2014. The outcome of the Accreditation visit was a cite free survey.
Current Gen. Ed and MA Faculty teaching courses in Anatomy and Physiology, Hematology, and Clinical Courses.

Received Faculty of the year award for 2014.

**Oct. 07 to July 14** **Herzing University, 5218 E. Terrace Drive, Madison WI 53718**
**Clinical Instructor MA and RN students, Director of Medical Assisting**
Developed syllabus objectives and course outline for MA and RN courses. Responsibilities of Program Chairman include coordinating MA Externships and MA Accreditation. Nursing and Medical Assistant Instructor for multiple courses in both programs. Clinical Nursing Instructor at Meriter Hospital, VA Hospital, Middleton Village Nursing and Rehabilitation Center, Central Wisconsin Center, Attic Angels Nursing Home, St. Mary's Hospital. Interim Director of Nursing from Feb 2011 to July 2011.

**Apr. 06 to Aug.09** **Middleton Village, 6201 Elmwood Ave, Middleton WI, 53562**
**Staff Development Coordinator**
Responsibilities for Staff Development for RN's, LPN's, and CNA's include orientation and in-service education, problem solving for staffing concerns, coaching and mentoring employees. Other responsibilities are Infection Control, Risk Management, and Employee Health and Human Resource.

**June 05 to Apr. 06** **Waunakee Manor Health Care Center, 801 S. Klein, Waunakee WI 53597**
**Nursing Supervisor**
Responsible for the supervision of R.N.'s L.P.N.'s and C.N.A's in a Skilled Nursing Facility and Assisted Living Facility. Duties include problem solving for staffing concerns, coaching and mentoring employees, and the overall management and coordination of patient care.

**June 99 to May 05** **Meriter Health Center, 334 W. Doty, St. Madison, WI. 53703**
Registered Nurse Pathways Unit
**12/00 to May 05 Nursing Supervisor, Pathways Unit.**
Responsible for the supervision of R.N.'s L.P.N.'s and C.N.A's on Sub-acute Rehabilitative Unit. Duties include problem solving for staffing and

## Baccalaureate Nursing Program Curriculum Plan

| Qtr | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| PRING/FALL | 4 cr CM 121 Composition<br>4 cr NS 135 Microbiology<br>4 cr SS 116 Introduction to Psychology<br>6 cr RN 101 Essentials of Professional Nursing<br>2 cr SS 103 Global Citizenship<br><br>**Credits: 20 credits/6 RN** | 5 cr RN 203 Care of the Adult in Illness II<br>8 cr RN 204 Nurse as Provider of Care<br>4 cr RN 206 Holistic Health Assessment<br><br>**Credits: 17 credits/17 RN** | 7 cr RN 401 Behavioral Health Ca<br>3 cr RN 403 Nursing Research & Evidence-Based Practice<br><br>**Credits: 10 RN** |
| SUMMER/WINTER | 4 cr NS 140 Anatomy & Physiology I<br>4 cr SS 210 Developmental Psychology<br>4 cr RN 154 Integrative Holistic Care<br>6 cr RN 152 Nursing Foundations<br><br>**Credits: 18 credits/10 RN** | 8 cr RN 302 Nurse as Provider and Coordinator of Care<br>3 cr RN 303 Family Health in Nursing<br>3 cr RN 304 Healthcare Issues Across the Lifespan<br><br>**Credits: 14 credits/14 RN** | 7 cr RN 408 Community Health Nursing<br>4 cr General Education Elective<br><br>**Credits: 11 credits/7 RN** |
| SPRING/FALL | 4 cr NS 150 Anatomy & Physiology II<br>6 cr RN 156 Health Promotion Across the Lifespan<br>3 cr MT 166 Introduction to Pharmacology<br>4 cr NS 116 College Algebra I<br><br>**Credits: 17 credits/6 RN** | 4 cr NS 305 Statistics I<br>**Choose either section A or section B.**<br>Section A:<br>7 cr RN305 Care of Children<br>4 cr RN404 Holistic End of Life<br><br>Section B:<br>7 cr RN306 Care of the Childbearing Family<br>4 cr RN307 Care of the Critically Ill Patient<br><br>**Credits: 14 credits/ 11 RN** | 7 cr RN 405 Leadership & Management in Nursing<br>4 cr General Education Elective<br>1 cr PD 250 Career Development<br><br>**Credits: 12 credits/7 RN** |
| SUMMER/WINTER | 3 cr MT 165 Nutrition & Supplementation<br>4 cr CM 200 Intercultural Communication<br>6 cr RN 201Care of the Adult in Illness I<br>4 cr RN 202 Nursing Pharmacology<br><br>**Credits: 17 credits/10 RN** | 4 cr CM 320 Writing & Research<br>**Choose either section A or section B.**<br>Section A:<br>7 cr RN305 Care of Children<br>4 cr RN404 Holistic End of Life<br><br>Section B:<br>7 cr RN306 Care of the Childbearing Family<br>4 cr RN307 Care of the Critically Ill Patient<br>**Credits: 14 credits/ 11 RN** | 3 cr RN 409 Nursing Within a Global Community<br>7 cr RN 413 Nursing Internship / Professional Role Developme<br><br>**Credits: 11 credits/10 RN** |
| | **Program Requirements:**<br><br>Nursing credits: 119<br>MT Credits: 6<br>General Ed. 54<br>PD: 1<br>180 Total Credits BSN<br><br>} Core Credits = 125<br>See * | * CM 121, 200, 320 = 12 credits<br>SS 103, 116, 210 = 10 credits<br>NS 116, 135, 140, 150, 305 = 20 credits<br>HU 6 credits Required (Choice)<br>Require at least 30% Upper Division courses for BSN Degree<br>74 RN + 8 GE UD credits = 82 UD credits = 45.5% UD | |

## OBJECTIVES

The Bachelor of Science in Nursing degree program is designed to prepare students for entry-level professional practice and provides an educational climate that stimulates lifelong learning. Students, through an evidence-based curriculum framework, learn essential competencies necessary to provide nursing care and leadership within diverse health care settings. General education requirements in the areas of communication, social science, natural science and humanities provide analytical and communication skills as well as a global perspective of diverse cultures.

Graduates of the Bachelor of Science in Nursing degree program are eligible to sit for the National Council Licensure Exam for Registered Nurses (NCLEX-RN) exam and, upon licensure, for entry-level professional practice.

The baccalaureate degree program in nursing at Minnesota School of Business-Richfield is approved by the Minnesota Board of Nursing and accredited by the Commission on Collegiate Nursing Education, One DuPont Circle NW, Suite 530, Washington, DC 20036, (202) 887-6791.

The goal of this program is to prepare graduates who are able to:

1. Integrate nursing knowledge with the humanities, arts and sciences to provide holistic care within the practice of professional nursing.
2. Demonstrate effective critical thinking, communication, assessment and technical skills in the practice of professional nursing.
3. Collaborate with patients, health care providers and other members of the interdisciplinary team to assess, plan, implement and evaluate patient focused outcomes.
4. Advocate for the patients and consumers of health care within health care delivery systems.
5. Use knowledge of health promotion, risk reduction and disease prevention in providing holistic care to individuals, families groups and communities.
6. Use knowledge of human diversity, global health care and information technology to promote the health care of individuals across the lifespan.
7. Apply research-based knowledge from nursing and the sciences as a foundation for evidence-based practice in maintaining, restoring and optimizing health.
8. Demonstrate values and ethical behaviors reflective of professional nursing practice.
9. Demonstrate self-awareness in identifying goals for life long professional development.
10. Incorporate leadership skills into the practice of professional nursing.
11. Demonstrate appropriate written and verbal communication skills.
12. Evaluate the quality of multiple viewpoints, arguments and evidence and distinguish between fact and opinion.
13. Exhibit social responsibility and examine the diverse cultures and value systems of our global community.

## CORE REQUIREMENTS

| Class # | Class Name | Credits |
|---|---|---|
| MT165 | Nutrition and Supplementation | 3 |
| MT166 | Introduction to Pharmacology | 3 |
| PD260 | Career Capstone | 2 |
| RN101 | Essentials of Professional Nursing | 6 |
| RN152 | Nursing Foundations [1,2] | 6 |
| RN154 | Integrative Holistic Care | 4 |
| RN156 | Health Promotion Across the Lifespan [1,2] | 6 |
| RN201 | Care of the Adult in Illness I | 6 |
| RN202 | Nursing Pharmacology [1] | 4 |
| RN203 | Care of the Adult in Illness II | 5 |
| RN204 | Nurse as Provider of Care [1,2] | 8 |
| RN206 | Holistic Health Assessment [1,2] | 4 |
| RN302 | Nurse as Provider and Coordinator of Care [1,2] | 8 |
| RN303 | Family Health in Nursing | 3 |
| RN304 | Health Care Issues Across the Lifespan | 3 |
| RN305 | Care of Children [2] | 7 |
| RN306 | Care of the Child Bearing Family [2] | 7 |
| RN307 | Care of the Critically Ill Patient [1] | 4 |
| RN401 | Behavioral Health Care [2] | 7 |
| RN403 | Nursing Research and Evidence-Based Practice | 3 |
| RN404 | Holistic End of Life Care [2] | 4 |
| RN405 | Leadership and Management in Nursing [2] | 7 |
| RN408 | Community Health Nursing [2] | 7 |
| RN409 | Nursing Within a Global Community | 3 |
| RN413 | Nursing Internship/Professional Role Development [2] | 7 |
| **Total Core Minimum Credit Requirement** | | **127** |

## NOTES

- [1] Lab sessions for these courses will be held in the skills lab located at the Richfield, MN campus.
- [2] These courses include practicum (experiential learning) components and are held at an external site.

» Students are responsible for providing their own reliable transportation when attending coursework at clinical sites.

» All applications submitted will be reviewed by the dean of nursing and a committee for consideration for acceptance to the program. The nursing department reserves the right to select those with the best qualifications from applicants who meet the minimum requirements. Applicants will not be accepted to the nursing program without approval by the dean of nursing. Refer to nursing program entrance requirements.

## GENERAL EDUCATION REQUIREMENTS

A student pursuing a bachelor's degree is required to earn a minimum of 54 credits from the general education courses listed below, demonstrating a solid grounding in the liberal arts. A minimum of six credits must be earned in each of the following disciplines: communications, humanities, natural science and mathematics, and social science.

| Class # | Class Name | Credits |
|---|---|---|
| **COMMUNICATIONS** | | |
| CM111 | Speech Communications | 4 |
| CM121 | Composition (required) | 4 |
| CM200 | Intercultural Communications (required) | 4 |
| CM210 | Creative Writing | 4 |
| CM320 | Writing and Research (required) | 4 |
| CM330 | Technical Writing | 4 |
| **HUMANITIES** | | |
| HU100 | Introduction to Humanities | 4 |
| HU121 | Film in Society | 4 |
| HU130 | Spanish I | 4 |
| HU145 | Global Influences on American Music | 4 |
| HU150 | Introduction to Literature | 4 |
| HU230 | Spanish II | 4 |
| HU315 | World Literature | 4 |
| **NATURAL SCIENCE and MATHEMATICS** | | |
| NS105 | Biology | 4 |
| NS111 | Environmental Issues | 4 |
| NS116 | College Algebra I (required) | 4 |
| NS126 | Chemistry Today* | 4 |
| NS135 | Microbiology (required)** | 4 |
| NS140 | Anatomy and Physiology I (required)** | 4 |
| NS150 | Anatomy and Physiology II (required)** | 4 |
| NS216 | College Algebra II | 4 |
| NS259 | Pre-Calculus | 4 |
| NS260 | Calculus | 4 |
| NS266 | Physics I*** | 4 |
| NS267 | Physics II*** | 4 |
| NS305 | Statistics (required) | 4 |
| NS320 | Introduction to Decision Systems | 4 |
| **SOCIAL SCIENCE** | | |
| SS103 | Global Citizenship (required) | 2 |
| SS116 | Introduction to Psychology (required) | 4 |
| SS140 | Interpersonal Relations | 4 |
| SS150 | Principles of Economics | 4 |
| SS205 | Sociology | 4 |
| SS210 | Developmental Psychology (required) | 4 |
| SS311 | Human Behavior | 4 |
| SS360 | Abnormal Psychology | 4 |
| **Total General Education Minimum Credit Requirement** | | **54** |
| **Total Program Minimum Credit Requirement** | | **181** |

## NOTES

- Students are required to complete 30 percent of the program at the 300/400 level.
- *Offered only at the Richfield, MN campus.
- **Nursing students must complete these courses residentially at the Richfield, MN campus.
- ***Offered only at the Woodbury, MN campus.

**RN101 Essentials of Professional Nursing 6 Credits**

Prerequisite: None. This course presents the history of nursing and nursing theory as an introduction to the profession and provides a framework for critical analysis of the role of the nurse in health care. Students learn professional values and ethical behaviors that guide nursing practice and the impact of research used to improve the care of individuals, families, groups, and communities.

**RN152 Nursing Foundations 6 Credits**

Prerequisite: RN101. This course introduces a patient-centered, analytical process for assessment, planning, implementing, and evaluating outcomes of care. Professional values and behaviors, caring practices, communication principles, technology, and decision-making skills are integrated in the context of a diverse patient population. Students apply those principles in clinical settings with an emphasis on the aging adult.

**RN154 Integrative Holistic Care 4 Credits**

Prerequisite: RN101. This is an introduction to holistic nursing as a theoretical milieu. Students explore the human caring process, therapeutic presence, global philosophies of health and healing, and the role of the nurse as a healer. An understanding of and appreciation for cultural diversity and human spirituality is woven throughout this course and sets the framework for students understanding of healing philosophies that guide principles and practices of complementary and alternative therapies. The course emphasizes the integration of complementary therapies into traditional nursing practice as a powerful healing modality.

**RN156 Health Promotion Across the Lifespan 6 Credits**

Prerequisites: RN152, RN154, SS210. This course expands on basic concepts of health promotion, risk reduction, and disease prevention across all age groups. It addresses the influences of family, culture, community, and environment on health. The course emphasizes risk assessment, the concept of self-care, and processes to identify and foster healthy lifestyle changes across the lifespan. Students apply knowledge of growth and development, sensitivity to personal and cultural definitions of health, and teaching-learning principles to promote health and wellness. A clinical experience includes the opportunity to observe wellness in children and adults in various community settings.

**RN201 Care of the Adult in Illness I 6 Credits**

Prerequisites: MT166, NS150, RN156. This course addresses the pathophysiology of illness and disease in adults and identifies the role of the professional nurse in assessment and collaborative management of symptoms. It explores individual and family/caregiver responses to illness and disease, with the goal of maximizing quality of life and maintaining optimal function. Students incorporate patient-centered care principles into planning and evaluating outcomes of care for the adult patient.

**RN202 Nursing Pharmacology 4 Credits**

Prerequisites: MT166, NS150, RN152. This course examines the role of the nurse in comprehensive care of patients that require pharmacological therapy, including use of natural alternative therapies as wellness or health promotion strategies. Content focuses on assessment of individualized needs across the lifespan.

**RN203 Care of the Adult in Illness II 5 Credits**

Prerequisite: RN201. This is a continuation of RN201 Care of the Adult in Illness I. Students synthesize knowledge of pathophysiology and symptom management in the care of patients with multiple medical conditions.

**RN204 Nurse as Provider of Care 8 Credits**

Prerequisites: CM200, RN201, RN202. This course expands upon the role of the nurse as a provider of care in planning, implementing, and evaluating nursing and medical interventions that promote health for patients. Students apply theoretical knowledge, scientific principles, and teaching/learning processes to patient care. The focus is on principles essential for acquiring and mastering technical skills and incorporating them into professional practice.

**RN206 Holistic Health Assessment 4 Credits**

Prerequisites: CM200, RN201. Students learn to perform holistic assessments of adults, incorporating influences that growth and development, family, environment, and culture may have on the health; they complete and document comprehensive health histories and physical exams of adults, including assessments related to health education needs. The course emphasizes physical assessment and health-related needs to the aging adult.

**RN302 Nurse as Provider and Coordinator of Care 8 Credits**

Prerequisites: RN203, RN204, RN206. This course focuses on synthesizing data and prioritizing care for multiple complex patients, including potential changes or adaptations to plans of care. Students expand their roles as providers of care and contributing members of interdisciplinary health care teams. The course emphasizes the role of the nurse as teacher and advocate for patient well-being and quality of life, as well as legal guidelines and ethical decision-making. Students use self-reflection and self-evaluation processes to enhance their growth in professional roles.

**RN303 Family Health in Nursing 3 Credits**

Prerequisites: RN156, RN206, SS210. This course explores principles of family dynamics, family theory, and care of the family. Through investigation of family memberships, students develop self-awareness and build foundations for providing nursing care to families. They perform holistic family assessments that include approaches for working with families in order to provide optimal nursing care. Students also, through construction of pedigrees from collected family histories, explore the relationships of genetics and genomics to family health.

**RN304 Health Care Issues Across the Lifespan 3 Credits**

Prerequisite: RN206. This course focuses on maintaining independence and wellness for individuals across the lifespan. It addresses normal growth and development, normal aging, and consideration for vulnerable populations with special needs, disabilities, and illness and emphasizes the role of the nurse in assisting individuals to maximize independence and quality of life. Students review access to care and referrals to appropriate resources in the context of social justice as a professional value.

**RN305 Care of Children 7 Credits**

Prerequisites: RN302, RN303, RN304. This course explores the well child and the needs of children requiring health care from infancy through adolescence. Through a family-centered approach, the course addresses health problems in children and the impact of illness on a child and the family. Students correlate normal growth and development with care of the ill child and promote healthy lifestyle strategies in the care of children.

**RN306 Care of the Child Bearing Family 7 Credits**

Prerequisites: RN302, RN303, RN304. This course covers care of the child bearing family, from preconception through postpartum and assessment and care of the newborn. It emphasizes promoting healthy pregnancy and birth within a family-centered care environment. It also addresses high-risk pregnancy, pregnancy complications, and nursing care of the high-risk newborn. Students apply family nursing theory as they care for families with new children.

**RN307 Care of the Critically Ill Patient 4 Credits**

Prerequisites: RN302, RN303, RN304. This course focuses on the unique health care needs of the critically ill patient and the impact of illness on the family and community. Students correlate pathophysiology with assessment and evaluate responses to interventions for patients requiring intensive nursing and medical care. Students further develop the roles of educator, collaborator, and advocate to care for patients and families in crisis.

**RN401 Behavioral Health Care 7 Credits**

Prerequisites: RN302, RN303, RN304. This course explores care of individuals, families, and communities experiencing alterations in mental health. Students investigate implications of living with an altered pattern of behavior and the impact on the family and community. The course emphasizes therapeutic use of self in establishing nurse-patient relationships, along with the nurse's role in collaborating with an interdisciplinary team to promote mental health.

**RN403 Nursing Research and Evidence-Based Practice 3 Credits**

Prerequisites: CM320, NS305, RN302, RN303, RN304. This course analyzes principles of research that improve patient outcomes and health of populations. Topics include research design and methodologies, ethics, protection of subjects, and the role of the nurse as a participant in research. Students critically analyze examples of nursing research and correlate findings with evidence of best practice in the care of individuals, families, and populations.

**RN404 Holistic End of Life Care 4 Credits**

Prerequisites: RN302, RN303, RN304. This course focuses on the physical and emotional needs of the patient and family at the end of life. Using an ethical decision-making framework, students explore ethical issues that may arise, such as trans-cultural and spiritual issues, practice issues related to life-support technology, and patient self-determination. The course addresses culturally competent care in the context of belief systems and values of the patient and family. Hospice care and the role of the hospice nurse are integrated into the study of care of the dying and the grieving family.

**RN405 Leadership and Management in Nursing 7 Credits**

Prerequisites: RN305, RN306, RN307, RN401, RN403, RN404. This course analyzes the role of the professional nurse as a manager and leader in health care systems and as a member of a profession. Students consider principles of management theory, leadership theory, conflict resolution, negotiation, and group process skills as they evaluate the role of the nurse as a designer, manager, and coordinator of care. The course also addresses methods to evaluate the quality of nursing care and analyze cost-effective health care delivery systems.

**RN408 Community Health Nursing 7 Credits**

Prerequisites: RN305, RN306, RN307, RN401, RN403, RN404. This course expands the focus of health care to the community and populations. Students assess and affect the health of individuals, families, and communities through participation in home visits, health screening, health promotion clinics, and education activities. The course addresses environmental health and safety, epidemiology, and communicable disease control affecting health of populations. Students review critical analysis of research and the role of the nurse as a change agent in forming public health policy.

**RN409 Nursing Within a Global Community 3 Credit**

Prerequisites: RN405, RN408. This course addresses the global environment as a context for health care and the role of nursing in promoting world health. Topics include the effects of disease transmission, health policy, bioterrorism, natural disasters, and economics on interconnected populations and on public health. The course addresses disaster planning, emergency response plans, and triage principles, and explores examples in which nursing advances world health by promoting collaboration and sharing of research between nations.

**RN413 Nursing Internship/Professional Role Development 7 Credits**

Prerequisites: RN404, RN405. This course prepares students for entry into professional practice. In an internship experience, students integrate professional nursing essentials and accountability with independent practice. Through a self-reflective process, students formulate goals for lifelong learning and professional development.

## PROFESSIONAL DEVELOPMENT

**PD160 Professional Communications I 4 Credits**

Prerequisite: None. This course introduces students to the skills and strategies needed to become effective communicators in business and professional settings. Students will learn basic communication skills to help them recognize the appropriate strategies to use when communicating verbally and in written form.

**PD200 Professional Communications II 4 Credits**

Prerequisite: None. In this course students learn advanced verbal and written skills to help them communicate professionally in the work place. Students will utilize effective written communication strategies to create business reports, preFsentations and professional correspondence.

**PD225 Applied Ethics 4 Credits**

Prerequisite: CM121 or PD200. This course introduces the student to ethical issues and how ethical frameworks can be used as a tool in career decision making and daily conduct. Students explore critical thinking techniques to apply in their chosen career field. Topics covered include foundations of ethics, applying ethics to your career field and ethics in the workplace. Students will apply concepts to career case studies.

**PD260 Career Capstone 2 Credits**

Prerequisite: Student must be within two quarters of completing coursework or one quarter before externship, if applicable. This course focuses on career exploration, job search tools and resources, and professionalism. Students develop career planning strategies in preparation for entering or advancing within their chosen career fields.

**PD350 Practicum 4 Credits**

Prerequisite: Last two quarters of program or with permission of dean of students/education and program chair. Certificate in Mental Health Technician Prerequisite: MH210. The practicum integrates program and general education training through hands-on applications in a workplace environment. Working under the direction and supervision of business owners, managers, supervisors or industry experts, students maintain ethical and professional work standards while applying classroom learning.

*Version #: 17 : September 18, 2015*

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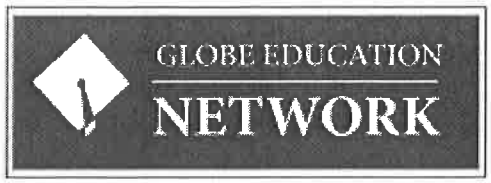


# RN101 Essentials of Professional Nursing Master Syllabus

## 6 Credit Hours - 60 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisite: None. This course presents the history of nursing and nursing theory as an introduction to the profession and provides a framework for critical analysis of the role of the nurse in health care. Students learn professional values and ethical behaviors that guide nursing practice and the impact of research used to improve the care of individuals, families, groups, and communities.

**TEXT/SUPPLIES:**

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*Contemporary Nursing: Issues, Trends, and Management*, Cherry, 6e, Elsevier, 2013

*Kozier & Erb's Fundamentals of Nursing*, Berman, 10e, Pearson Education, 2015

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Discuss the development of professional nursing through historical and contemporary perspectives.
2. Correlate the relationship of evidenced-based research to professional nursing practice and patient-centered outcomes.
3. Discuss professional values and ethical behaviors as the foundation for nursing practice.
4. Discuss core competencies and core knowledge relevant to the role of the professional nurse.
5. Interpret licensure laws, regulations and scope of practice.
6. Engage in Career Seeking activity: Distinguish the roles of the professional nurse as providers of care, designers/managers/coordinators of care and as members of a profession.
7. Discuss factors influencing the delivery of health care within a global community.
8. Identify and apply educational strategies to formulate a personal plan for professional growth as a nursing student and for life–long learning.
9. Engage in Career Readiness activity: Analyze the role of communication and personal attributes in social and professional interactions.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | | |

| | | |
|---|---|---|
| | Introduction of course<br>Development of professional nursing: history and contemporary | As assigned by instructor |
| Unit #2 | Nursing education<br>Nursing's distinctive knowledge | " |
| Unit #3 | Nursing process<br>Communication and learning within the nursing program | " |
| Unit #4 | Professional values<br>Professionalism | " |
| Unit #5 | Core competencies-critical thinking, communication, assessment, technical skills | " |
| Unit #6 | Core knowledge-health promotion, illness and disease management | " |
| Unit #7 | Core knowledge-human diversity, global health care | " |
| Unit #8 | Core knowledge-spirituality | " |
| Unit #9 | Health care systems and policies | " |
| Unit #10 | Evidenced-based practice | " |
| Unit #11 | Final exam and evaluation of learning | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including lecture, guest speakers, class discussion, group projects, ATI practice exams as applicable to content, and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Exams | 25% to 40% |
| Papers/projects | 35% to 50% |
| Class activities/discussion | 10% to 30% |
| Presentations | 10% to 20% |
| Professional accountability points | 2% to 4% |
| Essential competency evaluation | P/F |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes | Identify the roles and perspectives of the nursing profession regarding scope of practice, education, and licensure requirements. |

*Version #: 15 : December 16, 2015*

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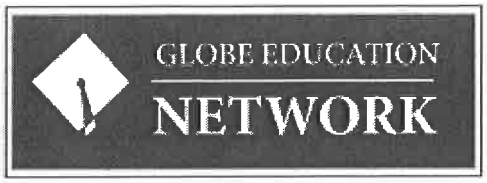



# RN154 Integrative Holistic Care Master Syllabus

## 4 Credit Hours - 40 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisite: RN101. This is an introduction to holistic nursing as a theoretical milieu. Students explore the human caring process, therapeutic presence, global philosophies of health and healing, and the role of the nurse as a healer. An understanding of and appreciation for cultural diversity and human spirituality is woven throughout this course and sets the framework for students understanding of healing philosophies that guide principles and practices of complementary and alternative therapies. The course emphasizes the integration of complementary therapies into traditional nursing practice as a powerful healing modality.

**TEXT/SUPPLIES:**

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*Kozier & Erb's Fundamentals of Nursing*, Berman, 10e, Pearson Education, 2015

**ADDITIONAL RESOURCES:**

ATI learning materials via web access; access (codes supplied by the nursing program).

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Describe the significance of health and healing across human societies.
2. Discuss holism as a means to promote healing through nursing care.
3. Discuss the principles of "spiritually sensitive" nursing care.
4. Contrast allopathic and holistic models of health care.
5. Explain the classifications of complementary and alternative (CAM) therapies.
6. Correlate the concept of therapeutic presence with the provision of holistic nursing care.
7. Explain common ideological principles underlying alternative therapies.
8. Research the benefits of holistic healing and CAM to client outcomes.
9. Recognize when one's own attitudes and values may affect care provided to patients, including genetic and genomic science.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Use of complementary integrative therapies in practice<br>Philosophy of service learning | As assigned by instructor |
| Unit #2 | Philosophy of holism and the nurse as a holistic healer<br>Core values of holistic nursing | As assigned by instructor |
| Unit #3 | Art of holistic communication and nursing presence<br>• Therapeutic listening | As assigned by instructor |

| | | |
|---|---|---|
| | • Art of presence<br>Art of promoting a healing environment | |
| Unit #4 | Spirituality: Concepts of health, religion and culture | As assigned by instructor |
| Unit #5 | Nurse as spiritual care provider | As assigned by instructor |
| Unit #6 | Healing potentials: Healing the healer | As assigned by instructor |
| Unit #7 | The mind body connection: Mind-body therapies | As assigned by instructor |
| Unit #8 | Energy and biofield therapies | As assigned by instructor |
| Unit #9 | Biologically based therapies | As assigned by instructor |
| Unit #10 | Manipulative and body based therapies | As assigned by instructor |
| Unit #11 | Final exam | As assigned by instructor |

**PORTFOLIO ASSIGNMENTS:**

Applied learning reflection assignment

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, role playing exercises, ATI practice exams, demonstration of CAM, reflective journaling, and applied learning techniques. This course uses workplace application or service-learning as a form of applied learning.

**MODE OF INSTRUCTION:**

May be taught residentially .

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI practice exams | 40% to 80% |
| Papers/projects/presentations | 20% to 50% |
| Service learning reflection journal | P/F Competency |
| Class activities/discussion | 10% to 30% |
| Essential Competency Evaluation | P/F Competency |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VIII: Professionalism and Professional Values | Develop awareness of spiritual well-being based on individual beliefs and values. |

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

| | |
|---|---|
| A | 90% - 100% |
| B | 80% - 89% |
| C | 70% - 79% |
| D | 60% - 69% |
| F | Below 60% |

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN101 ]

*Version #: 17 : December 16, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN152 Nursing Foundations Master Syllabus

## 6 Credit Hours - 100 Hours (Lecture 30/Lab 40/Practicum 30)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisite: RN101. This course introduces a patient-centered, analytical process for assessment, planning, implementing, and evaluating outcomes of care. Professional values and behaviors, caring practices, communication principles, technology, and decision-making skills are integrated in the context of a diverse patient population. Students apply those principles in clinical settings with an emphasis on the aging adult.

**TEXT/SUPPLIES:**

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*HIPAA for Allied Health Careers*, Newby, 1e, McGraw, 2008

*Immortal Life of Henrietta Lacks*, Skloot, 1e, Random House, 2011

*Kozier & Erb's Fundamentals of Nursing*, Berman, 10e, Pearson Education, 2015

*Nursing Diagnosis Manual: Planning, Individualizing, and Documenting Care*, Doenges, 4e, F.A. Davis, 2013

*Unlocking Medical Terminology*, Wingerd, 2e, Pearson Education, 2010

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access; access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**COURSE OBJECTIVES:**

1. Discuss the scientific method as a basis for assessment, planning implementing and evaluating outcomes of care.
2. Discuss the impact of patient-centered care towards improving health and outcomes of care.
3. Correlate usage of communication skills, informatics and health care technology with professional nursing practice and patient outcomes.
4. Integrate knowledge of human diversity into professional practice.
5. Develop professional values and behaviors as a framework for providing safe, ethical care.
6. Utilize an analytic process to assess, plan, implement and evaluate patient care in lab and simulation settings.
7. Apply critical thinking skills to patient care scenarios or simulations.
8. Utilize nursing informatics to promote safe, ethical care in a patient care scenario or simulation experience.
9. Engage in a Career Speaking activity: Apply knowledge of medical terminology in lab and simulation settings.

10. Demonstrate competence in the performance of a basic head to toe assessment.
11. Demonstrate cultural competency in the provision of care in a patient care scenario or simulation experience.
12. Identify relevance of genetics/genomics to nursing practice.
13. Integrate relevant concepts of aging into the delivery of patient-centered care for older adults.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Patient-centered care including aging concepts and genetics and genomics issues | As assigned by instructor |
| Unit #2 | The nursing process: process and assessment | As assigned by instructor |
| Unit #3 | The nursing process: diagnosis and planning | As assigned by instructor |
| Unit #4 | The nursing process: interventions, implementation and evaluation | As assigned by instructor |
| Unit #5 | Response to illness and adaptation | As assigned by instructor |
| Unit #6 | Documentation and informatics | As assigned by instructor |
| Unit #7 | Cultural and spiritual competency | As assigned by instructor |
| Unit #8 | Ethics and values | As assigned by instructor |
| Unit #9 | HIPAA and patient rights | As assigned by instructor |
| Unit #10 | Legal issues | As assigned by instructor |
| Unit #11 | Final exam | As assigned by instructor |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams online learning medical terminology modules, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI Practice Exams | 40% to 80% |
| Papers/projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F Competency |
| | P/F Competency |

Skills/nursing interventions and Essential Competency Evaluation

Professional accountability 2% to 4%

Nursing grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential I: Liberal Education for Baccalaureate nursing Practice<br>Essential IX: Baccalaureate Generalist Nursing Practice | Use verbal and nonverbal communication skills and cultural competence to establish a therapeutic nurse-patient relationship. |
| Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Options | Maintain professional boundaries in nurse-patient relationships, within institutional policy, and in use of electronic or social media. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Gather and interpret data pertaining to a patient's physical, emotional, spiritual and cultural needs. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Identify priorities of care based on interpretation of assessment data and patient-centered needs. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Provide for physical safety including prevention of spread of pathogens, promotion of personal hygiene, nutrition and fluid balance, and physical activity. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Promote adaptation to life changes with respect for individual and family preferences. |
| Essential IV: Information Management and Application of Patent Care Technology<br>Essential VIII: Professionalism and Professional Values | Uphold ethical standards related to data security, maintain confidentiality of patient information, and recognize patients' rights to privacy. |
| Essential VIII: Professionalism and Professional Values<br>Essential IX: Baccalaureate Generalist Nursing Practice | Evaluate the effectiveness of and maintain the accountability for nursing actions in a patient care setting. |
| Essential VII: Clinical Prevention and Population Health<br>Essential IX: Baccalaureate Generalist Nursing Practice | Incorporate professional attitudes, values, and expectations about physical and mental aging in the provision of patient-centered care for older adults and their families. |

**CLINICAL COMPETENCIES:**

The student will apply learning with emphasis on the aging individual in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN101 ]

*Version #: 12 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN156 Health Promotion Across the Lifespan Master Syllabus

## 6 Credit Hours - 90 Hours (Lecture 40/Lab 20/Clinical 30)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN152, RN154, SS210. This course expands on basic concepts of health promotion, risk reduction, and disease prevention across all age groups. It addresses the influences of family, culture, community, and environment on health. The course emphasizes risk assessment, the concept of self-care, and processes to identify and foster healthy lifestyle changes across the lifespan. Students apply knowledge of growth and development, sensitivity to personal and cultural definitions of health, and teaching-learning principles to promote health and wellness. A clinical experience includes the opportunity to observe wellness in children and adults in various community settings.

### TEXT/SUPPLIES:

*Bridges Out of Poverty*, Payne, Revised edition, aha! Process, Inc., 1999

*Health Promotion in Nursing*, Maville, 3e, Cengage Learning, 2012

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Differentiate the concepts of health, wellness, health promotion, risk reduction and disease prevention.
2. Discuss the influence of family, culture, community and socioeconomic status on the health of children and adults.
3. Recognize variables that affect the health of all age groups.
4. Apply principles of teaching-learning to health promotion across age groups.
5. Interpret the relationship between culture and an individual's definitions of health and illness.
6. Identify ways to promote health along a continuum of growth from infancy through older adulthood.
7. Explore the concept of self-care as a means to promote health.
8. Assess predictive factors, including genetics, which influence the health of individuals.

### COURSE OUTLINE:

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Health promotion concepts | As assigned by instructor |
| Unit #2 | Health promotion and the nursing process | " |

| | | |
|---|---|---|
| Unit #3 | Health promotion within the individual/family/community framework | " |
| Unit #4 | Therapeutic communication and professional boundaries | " |
| Unit #5 | Health promotion teaching/learning principles | " |
| Unit #6 | Nutrition, exercise, stress management, holistic strategies for health promotion | " |
| Unit #7 | Principles of growth and development with health promotion | " |
| Unit #8 | Health promotion for newborns and infants, toddlers and pre-schoolers | " |
| Unit #9 | Health promotion for school age children and adolescents | " |
| Unit #10 | Health promotion for adults | " |
| Unit #11 | Final exam and evaluation of learning | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Exams | 30% to 40% |
| Papers/projects | 40% to 50% |
| Class activities/discussion | 15% to 30% |
| Clinical competency | P/F competency |
| Lab competency | P/F competency |
| Professional accountability points | 2% to 4% |

Nursing Grades are not rounded up when calculating grades.

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to use knowledge of human diversity, global health care and information technology to promote the health care of individuals across the lifespan.

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)

- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

| | |
|---|---|
| A | 90% - 100% |
| B | 80% - 89% |
| C | 70% - 79% |
| D | 60% - 69% |
| F | Below 60% |

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

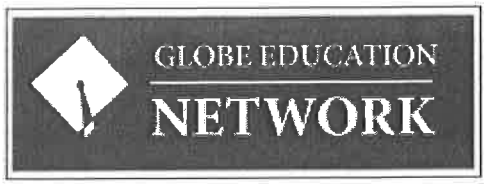
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN152 ] And [ RN154 ] And [ SS210 ]

*Version #: 12 : September 18, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN201 Care of the Adult in Illness I Master Syllabus

## 6 Credit Hours - 60 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: MT166, NS150, RN156. This course addresses the pathophysiology of illness and disease in adults and identifies the role of the professional nurse in assessment and collaborative management of symptoms. It explores individual and family/caregiver responses to illness and disease, with the goal of maximizing quality of life and maintaining optimal function. Students incorporate patient-centered care principles into planning and evaluating outcomes of care for the adult patient.

**TEXT/SUPPLIES:**

*Clinical Nursing Judgment Study Guide for Medical-Surgical Nursing*, Ignatavicius, 8e, Elsevier, 2015

*Medical-Surgical Nursing: Patient-Centered Collaborative Care, Single Vol.*, Ignatavicius, 8e, Elsevier Science, 2015

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Integrate knowledge from the behavioral, biological and natural sciences in the study of disease and illness in the adult patient.
2. Differentiate between normal physiologic function and pathologic processes in selected diseases.
3. Utilize critical thinking and analysis of data to interpret diagnostic and laboratory values.
4. Differentiate common diagnostic and treatment options and treatment modalities for each illness/disease process presented.
5. Integrate use of the scientific process and critical thinking with adults experiencing illness to assess, plan, implement and evaluate outcomes of care.
6. Incorporate collaborative treatment options and nursing interventions into a holistic patient-centered plan of care.
7. Demonstrate sensitivity to personal and cultural influences on the individual's and families reactions to the illness experience.
8. Discuss learning/teaching needs of patients with alterations in health.
9. Incorporate results of research into a plan of care.
10. Explore social and psychological responses of patients and families regarding genetic/ genomic diagnoses and information.
11. Integrate knowledge of genetic and genomic-based interventions and information into a holistic plan of care.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction<br>Fluid and electrolyte imbalance | As assigned by instructor |
| Unit #2 | Fluid and electrolyte imbalance<br>Care of the surgical patient | As assigned by instructor |
| Unit #3 | Care of the surgical patient<br>Care of the patient with cardiovascular disorders | As assigned by instructor |
| Unit #4 | Care of the patient with cardiovascular disorders | As assigned by instructor |
| Unit #5 | Care of the patient with respiratory disorders | As assigned by instructor |
| Unit #6 | Care of the patient with respiratory disorders | As assigned by instructor |
| Unit #7 | Care of the patient with endocrine disorders | As assigned by instructor |
| Unit #8 | Care of the patient with hematologic and immune disorders | As assigned by instructor |
| Unit #9 | Care of the patient with gastrointestinal disorders | As assigned by instructor |
| Unit #10 | Care of the patient with urologic disorders | As assigned by instructor |
| Unit #11 | Final Exam | As assigned by instructor |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including lecture, class discussion, virtual clinical excursion exercises, group projects, ATI practice exams as applicable to content, and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ NS150 ] And [ MT166 ] And [ RN153 Or RN156 ]

*Version #: 12 : May 13, 2014*

**Globe University - Minnesota School of Business**
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# RN202 Nursing Pharmacology Master Syllabus

## 4 Credit Hours - 60 Hours (Lecture 20/Lab 40)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: MT166, NS150, RN152. This course examines the role of the nurse in comprehensive care of patients that require pharmacological therapy, including use of natural alternative therapies as wellness or health promotion strategies. Content focuses on assessment of individualized needs across the lifespan.

**TEXT/SUPPLIES:**

*Calculation of Drug Dosages*, Ogden, 9e, Elsevier, 2011

*Nursing Case Studies, Custom*, Kelly, 2e, Cengage Learning, 2012

*Pharmacology for Nursing Care*, Lehne, 8e, Elsevier Science, 2012

*Study Guide for Pharmacology for Nursing Care*, Lehne, 8e, Elsevier, 2012

**ADDITIONAL RESOURCES:**

ATI learning materials via web access; access (codes supplied by the nursing program).

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Discuss regulatory agencies and legislation that help to ensure drug quality and safety.
2. Differentiate scope of practice and legal issues related to prescription and administration of drugs.
3. Discuss the role of the professional nurse in clinical trials and research related to pharmacological interventions.
4. Integrate cultural beliefs and values of patients regarding use of pharmaceuticals and natural alternative therapies into a patient-centered plan of care.
5. Correlate theoretical principles of pharmacology with needs of the patient requiring pharmacological therapy.
6. Incorporate assessment data into planning, implementing and evaluating outcomes of care related to pharmacological intervention.
7. Discuss the application of professional nursing values into care of the patient requiring pharmacological intervention.
8. Discuss the relationship of pharmacological therapy and natural alternative therapies to health promotion and disease management.
9. Incorporate safe drug administration concepts and skills into practice.
10. Demonstrate administration of drugs utilizing multiple routes, including intravenous.
11. Demonstrate dosage calculation competency for pediatric and adult patients.
12. Demonstrate ethical behaviors in the provision of drug administration.
13. Distinguish the needs of the aging adult and the therapeutic use of pharmaceuticals.
14. Differentiate and evaluate genetic/genomic based therapies (pharmacogenetics, pharmacogenomics).

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Review of pharmacology basics and substance abuse | As assigned by instructor |
| Unit #2 | Life span, nutrition, culture and diversity | As assigned by instructor |
| Unit #3 | Peripheral nervous system drugs and opioids | As assigned by instructor |
| Unit #4 | Cardiovascular drugs #1 | As assigned by instructor |
| Unit #5 | Cardiovascular drugs #2 | As assigned by instructor |
| Unit #6 | Immune (pt. 1) and respiratory drugs | As assigned by instructor |
| Unit #7 | Neurological drugs | As assigned by instructor |
| Unit #8 | Endocrine drugs | As assigned by instructor |
| Unit #9 | Immune (pt. 2) & gi drugs | As assigned by instructor |
| Unit #10 | Cancer (pt. 1) | As assigned by instructor |
| Unit #11 | Final exam | Comprehensive |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing pharmacology skills/interventions demonstrations; simulation exercises, ATI practice exams, and online dosage calculation learning modules.

**MODE OF INSTRUCTION:**

May be taught residentially.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Dosage calculation competency/Essential Competency Evaluation | P/F Competency |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential III: Scholarship for Evidence-Based Practice<br><br>Essential IV: Information Management and Application of Patient Care Technology | Use valid pharmacological resources to support knowledgeable and safe administration of prescribed medication |

| | |
|---|---|
| Essential IX: Baccalaureate Generalist Nursing Practice | |
| Essential I: Liberal Education for Baccalaureate nursing Practice<br><br>Essential III: Scholarship for Evidence-Based Practice<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Use critical reasoning to calculate and determine safe dosages necessary to administer prescribed medication |
| Essential I: Liberal Education for Baccalaureate nursing Practice<br><br>Essential III: Scholarship for Evidence-Based Practice<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Use critical reasoning to determine the appropriateness of route to administer prescribed medication |
| Essential IV: Information Management<br>and Application of Patient Care Technology<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Prepare and administer prescribed medication for administration utilizing multiple routes; including enteral, parenteral, topical, optic, otic, transdermal, rectal, vaginal, intravenous routes. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Adhere to regulatory policy for controlled substances in the administration of prescribed medication |

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ NS150 ] And [ MT166 ] And [ RN152 ]

*Version #: 13 : September 18, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN203 Care of the Adult in Illness II Master Syllabus

## 5 Credit Hours - 50 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisite: RN201. This is a continuation of RN201 Care of the Adult in Illness I. Students synthesize knowledge of pathophysiology and symptom management in the care of patients with multiple medical conditions.

**TEXT/SUPPLIES:**

*Clinical Nursing Judgment Study Guide for Medical-Surgical Nursing*, Ignatavicius, 8e, Elsevier, 2015

*Medical-Surgical Nursing: Patient-Centered Collaborative Care, Single Vol.*, Ignatavicius, 8e, Elsevier Science, 2015

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Integrate knowledge from the behavioral, biological and natural sciences in the study of disease and illness in the adult patient.
2. Differentiate between normal physiologic function and pathologic processes in selected diseases.
3. Utilize critical thinking and analysis of data to interpret diagnostic and laboratory values.
4. Differentiate common diagnostic and treatment options and treatment modalities for each illness/disease process presented.
5. Integrate use of the scientific process and critical thinking with adults experiencing illness to assess, plan, implement and evaluate outcomes of care.
6. Incorporate collaborative treatment options and nursing interventions into a holistic patient-centered plan of care.
7. Demonstrate sensitivity to personal and cultural influences on the individual's and families reactions to the illness experience.
8. Discuss learning/teaching needs of patients with alterations in health.
9. Synthesize knowledge of pathophysiology and symptom management in the care of patients with multiple medical conditions.
10. Engage in a Career Writing activity: Incorporate results of research into a plan of care.
11. Discuss the interaction of multiple factors affecting the health of the aging adult, including geriatric syndromes.

12. Integrate knowledge of genetic and genomic-based interventions and information into a holistic plan of care.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Care of the patient with altered neurologic status: increased intracranial pressure | As assigned by instructor |
| Unit #2 | Care of the patient with altered neurologic status: stroke, spinal cord injury | " |
| Unit #3 | Care of the patient in shock<br>Care of the patient with infectious disease | " |
| Unit #4 | Care of the patient with sensory disorders including visual and hearing disorders<br>Care of the patient with changes due to normal aging | " |
| Unit #5 | Care of the patient with musculoskeletal disorders | " |
| Unit #6 | Care of the patient in pain<br>Care of the perioperative patient | " |
| Unit #7 | Care of the patient with alterations in the integument: burn injury, skin cancer, pruritus, infectious disorders, acquired disorders | " |
| Unit #8 | Care of the patient with hematologic disorders: white blood cell disorders, autoimmune disorders, leukemia, lymphoma and cancer | " |
| Unit #9 | Care of the patient with sexually transmitted disease<br>Care of the male patient reproductive health and with disease | " |
| Unit #10 | Care of the female patient reproductive health and with disease | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including lecture, class discussion, virtual clinical excursion exercises, group projects, ATI practice exams as applicable to content, and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes, exams & ATI proctored exam | 30% to 60% |
| Papers/projects | 30% to 40% |
| Class activities/discussion | 15% to 30% |
| Professional accountability points | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN201 ]

*Version #: 13 : May 13, 2014*

**Globe University - Minnesota School of Business**
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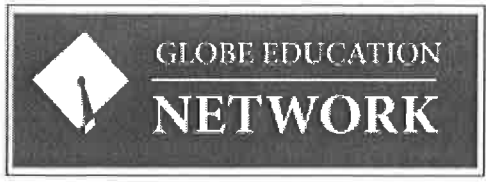



# RN204 Nurse as Provider of Care Master Syllabus

## 8 Credit Hours - 150 Hours (Lecture 30/Lab 60/Practicum 60)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: CM200, RN201, RN202. This course expands upon the role of the nurse as a provider of care in planning, implementing, and evaluating nursing and medical interventions that promote health for patients. Students apply theoretical knowledge, scientific principles, and teaching/learning processes to patient care. The focus is on principles essential for acquiring and mastering technical skills and incorporating them into professional practice.

### TEXT/SUPPLIES:

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*Kozier & Erb's Fundamentals of Nursing*, Berman, 9e, Pearson Education, 2010

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Integrate scientific theory and research based knowledge into patient assessment, planning and evaluation related to implementation of technical skills and interventions.
2. Analyze effects of interventions related to achievement of patient-centered outcomes.
3. Integrate basic teaching/learning processes in the provision of health education into the care of the patient with identified learning needs.
4. Utilize communication processes and technology to promote safe implementation and documentation of care.
5. Demonstrate competency related to interventions that promote adaptation in the patient with alterations in health.
6. Demonstrate basic competency in the provider of care role of the nurse in the clinical setting.
7. Identify situations where the patient's own beliefs and or values influence genetic and genomic care choices.
8. Recognize the complex interaction of acute and chronic co-morbid physical and mental conditions and associated treatments related to the care of older adults.

### COURSE OUTLINE:

| Units | Topics/Activities | Reading |
|---|---|---|
| | | |

| | | |
|---|---|---|
| Unit #1 | Teaching and learning<br>Stress adaptation<br>Asepsis | As assigned by instructor |
| Unit #2 | Skin integrity & wound healing | " |
| Unit #3 | Oxygenation part 1 | " |
| Unit #4 | Oxygenation part 2 | " |
| Unit #5 | Nutrition<br>Sleep and rest | " |
| Unit #6 | Perioperative nursing care | " |
| Unit #7 | Genitourinary function and elimination (review of fluids and electrolytes) part 1 | " |
| Unit #8 | Genitourinary function part 2 | " |
| Unit #9 | Gastrointestinal function and elimination | " |
| Unit #10 | Nursing philosophy development | " |
| Unit #11 | Final exam | " |

**PORTFOLIO ASSIGNMENTS:**

Personal philosophy of nursing

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI practice exams | 50% to 60% |
| Papers/projects | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Professional accountability points | 2% to 4% |
| Lab: skills competency | P/F |
| Clinical competency | P/F |
| Essential Competencies | P/F |

Nursing grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VII: Clinical Prevention and Population Health<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Apply principles of infection control that contributes to a safe environment and quality outcomes. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Conduct focused assessments related to a patient's physical and physiological function and analyze data to provide patient–centered care. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Conduct focused assessments related to a patient's intellectual, emotional, and social function and analyze data to provide patient–centered care. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Implement evidence-based nursing interventions to promote physiological function within body systems; respiratory, circulatory, gastrointestinal, genitourinary, musculoskeletal and integumentary. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Implement evidence-based nursing interventions for managing acute and chronic conditions, including pain, for optimum outcomes. |
| Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety | Identify factors that create a culture of safety and caring. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Monitor patient outcomes to evaluate the effectiveness of interventions. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Facilitate patient-centered transitions of care to ensure continuity of care by any others involved, including discharge planning and caregiver knowledge. |
| Essential VIII: Professionalism and Professional Values | Demonstrate accountability for professional behaviors and moral, ethical, and legal conduct. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Develop, implement, evaluate and revise a plan of care based on an ongoing evaluation of patient outcomes. |
| Essential IV: Information Management and Application of Patient Care Technology | Demonstrate skill in using patent care technologies, information systems, and communication devices that support safe practice. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate efficient, safe and caring application of psychomotor skills. |

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ CM200 ] And [ RN201 ] And [ RN202 ]

*Version #: 9 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN206 Holistic Health Assessment Master Syllabus

## 4 Credit Hours - 50 Hours (Lecture 30/Lab 20)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: CM200, RN201. Students learn to perform holistic assessments of adults, incorporating influences that growth and development, family, environment, and culture may have on the health; they complete and document comprehensive health histories and physical exams of adults, including assessments related to health education needs. The course emphasizes physical assessment and health-related needs to the aging adult.

**TEXT/SUPPLIES:**

*Physical Examination and Health Assessment*, Jarvis, 6e, Elsevier, 2011

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Demonstrate the skills and techniques of history taking, data collection, and physical assessment to perform and record a comprehensive health history and physical examination for the adult patient.
2. Demonstrate holistic assessment of the person, including development, culture, spiritual, mental status, nutrition, health, illness and health promotion.
3. Demonstrate the ability to recognize normal findings on a physical assessment of an adult and geriatric patient.
4. Utilize the appropriate technique in completion of various physical assessment skills related to multi body systems.
5. Describe the difference between normal and abnormal findings upon assessment of the body systems.
6. Demonstrate correct assessment techniques when inspecting, palpation, percussing and auscultating the adult client.
7. Demonstrate effective interviewing skills and data collection when completing a health assessment for an adult, and recognize needed adaptations to meet the specific needs of the older adult patient.
8. Recognize differing needs of the older adult in receiving, understanding, and giving of information.
9. Collect personal, health, and developmental histories that consider genetic, environmental, and genomic influences and risks.
10. Identify factors in a family and health history that contribute to: disease susceptibility, disease characteristics, treatment, prognosis; or genetic/genomic condition.
11. Critically analyze the history and physical assessment findings for genetic, environmental, and genomic influences and risk factors.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Holistic health history and assessment techniques<br>Cultural and spiritual assessment<br>Healthy aging | As assigned by instructor |
| Unit #2 | Mental health and domestic violence assessment/family dynamics<br>Neurological system assessment | " |
| Unit #3 | Head and neck: eye, ear, nose, throat assessments<br>Integumentary system assessment | " |
| Unit #4 | Lymphatic and regional lymph nodes | " |
| Unit #5 | Chest and thorax: respiratory system assessment | " |
| Unit #6 | Chest and thorax: cardiovascular system assessment | " |
| Unit #7 | Abdomen: gastrointestinal system assessment<br>Nutritional assessment | " |
| Unit #8 | Musculoskeletal system assessment | " |
| Unit #9 | Genitourinary system assessment | " |
| Unit #10 | Male and female reproductive system assessment | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing assessment demonstrations, simulation exercises, and ATI practice exams.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI practice | 30% to 40% |
| Papers/projects | 40% to 50% |
| Class activities/discussion | 15% to 30% |
| Lab competency | P/F |
| Essential Competency evaluation | P/F |
| Professional accountability points | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VII: Clinical Prevention and Population Health | Conduct a health history that recognizes signs and symptoms of violence and abuse, or self-destructive behavior |
| | |

| | |
|---|---|
| Essential VII: Clinical Prevention and Population Health | Create a pedigree from a family health history and analyze for genetic risks to current and future health problems. |
| Essential I: Liberal Education for Baccalaureate nursing Practice<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate effective adaptation to interviewing skills and analysis of data when completing a health assessment for an aging adult. |

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to demonstrate effective caring and watching over behaviors, critical thinking, communication, assessment, and evidence-based nursing interventions in the practice of professional nursing.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ CM200 ] And [ RN201 ]

*Version #: 17 : December 16, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN302 Nurse as Provider and Coordinator of Care Master Syllabus

## 8 Credit Hours - 150 Hours (Lecture 30/Lab 60/Practicum 60)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN203, RN204, RN206. This course focuses on synthesizing data and prioritizing care for multiple complex patients, including potential changes or adaptations to plans of care. Students expand their roles as providers of care and contributing members of interdisciplinary health care teams. The course emphasizes the role of the nurse as teacher and advocate for patient well-being and quality of life, as well as legal guidelines and ethical decision-making. Students use self-reflection and self-evaluation processes to enhance their growth in professional roles.

**TEXT/SUPPLIES:**

*2016 Intravenous Medications: A Handbook for Nurses & Health Professionals*, Gahart, 32e, Elsevier, 2015

*Clinical Nursing Judgment Study Guide for Medical-Surgical Nursing*, Ignatavicius, 8e, Elsevier, 2015

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*Kozier & Erb's Fundamentals of Nursing*, Berman, 9e, Pearson Education, 2010

*Medical-Surgical Nursing: Patient-Centered Collaborative Care, Single Vol.*, Ignatavicius, 8e, Elsevier Science, 2015

*Nursing Case Studies, Custom*, Kelly, 2e, Cengage Learning, 2012

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access; access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Incorporate clinical judgment and decision-making skills into complex patient and family situations.
2. Employ analytic processes in the management and care for the complex patient or multiple patients.
3. Utilize critical thinking processes to plan, prioritize, implement and evaluate outcomes of care for the complex patient or multiple patients.
4. Anticipate and manage complications of illness leading to potential change or adaptation of the plan of care.
5. Incorporate ethical decision-making processes and legal guidelines within the role of the professional nurse to advocate for patient-centered care outcomes.
6. Discuss the role of the nurse as a member of the interdisciplinary team and as a manager of care in an outcome-based model of practice.

7. Incorporate skills of delegation and supervision into the role of the professional nurse.
8. Utilize teaching/learning principles to provide relevant and sensitive health information and counseling.
9. Utilize self-reflection and evaluation processes to expand development of professional values, behaviors and insight into own nursing role.
10. Demonstrate competency in integration of higher order professional nursing roles into the care of patients and families in the clinical setting.
11. Identify sources of referral available to patient's seeking genetic/genomic information or services.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Professional role development (pt. 1):<br>Organization, time-management, prioritization, communication | As assigned by instructor |
| Unit #2 | Professional role development (pt. 2)<br>Life-long learning, certification, & advanced practice | As assigned by instructor |
| Unit #3 | Interdisciplinary model of care and nurse coordinator role, "Watching Over" | As assigned by instructor |
| Unit #4 | Professional roles of delegation, supervision, and accountability | As assigned by instructor |
| Unit #5 | Legal guidelines and advocacy and application in patient-centered care | As assigned by instructor |
| Unit #6 | Teaching/ learning, patient and family education and counseling | As assigned by instructor |
| Unit #7 | Management and care of patients with multiple conditions, including adaptation to the plan of care (pt. 1):<br>GI & GU/renal focus | As assigned by instructor |
| Unit #8 | Management and care of patients with multiple conditions, including adaptation to the plan of care (pt. 2):<br>Cardiac & respiratory focus | As assigned by instructor |
| Unit #9 | Management and care of patients with multiple conditions, including adaptation to the plan of care (pt. 3):<br>Neuro & endocrine focus | As assigned by instructor |
| Unit #10 | Ethical-decision making framework and application in patient-centered care | As assigned by instructor |
| Unit #11 | Final Exam | As assigned by instructor |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 40% to 80% |

| | |
|---|---|
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F Competency |
| Dosage calculation competency | P/F Competency |
| Skills/nursing interventions and Essential Competency Evaluation | P/F Competency |
| Professional accountability | 2% to 4% |

Nursing Grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential IX: Baccalaureate Generalist Nursing Practice | Deliver patient-centered care that respects patient and family preferences and promotes a feeling of psychological safety and comfort. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate efficient, safe and caring application of psychomotor skills. |
| Essential VII: Clinical Prevention and Population Health | Use evidence-based practices to guide health-teaching and patient education according to age, culture, spirituality, patent preferences, and health literacy. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate clinical judgment and accountability for patient outcomes when delegating to and supervising other members of the healthcare team. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Develop, implement, evaluate and revise a plan of care based on an ongoing evaluation of patient outcomes. |
| Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes | Advocate for quality and safe patient care as a member of the interprofessional team. |

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

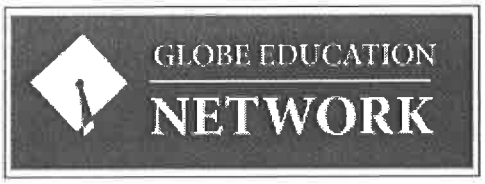
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN203 ] And [ RN204 ] And [ RN206 Or RN301 Or RN314 ]

*Version #: 12 : March 17, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN303 Family Health in Nursing Master Syllabus

## 3 Credit Hours - 30 Hours (Lecture)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN156, RN206, SS210. This course explores principles of family dynamics, family theory, and care of the family. Through investigation of family memberships, students develop self-awareness and build foundations for providing nursing care to families. They perform holistic family assessments that include approaches for working with families in order to provide optimal nursing care. Students also, through construction of pedigrees from collected family histories, explore the relationships of genetics and genomics to family health.

### TEXT/SUPPLIES:

*Family Health Care Nursing*, Kaakinen, 5e, F.A. Davis, 2014

### ADDITIONAL RESOURCES:

ATI learning materials via web access (codes supplied by the nursing program).

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Analyze the concept of family.
2. Differentiate between types of families and family structures.
3. Discuss challenges to family health related to genetics, environment, socio-economics, cultural beliefs, and access to health care.
4. Distinguish roles and functions of families and individuals within a family.
5. Integrate family theory with nursing knowledge to promote care of the family.
6. Distinguish the components of a holistic family assessment.
7. Apply theoretical knowledge within a comprehensive family assessment.
8. Discuss the impact of human diversity and culture on family roles and function of family members.
9. Illustrate the role of the professional nurse within the care of families.
10. Explore family membership as a means to develop self-awareness in providing holistic nursing care to a family.
11. Demonstrate the ability to assess cultural, language, family values, traditions, health beliefs and religious perspectives that influence access to and use of genetic/genomic information, technology, and services.

### COURSE OUTLINE:

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction and theoretical foundations in family health nursing | As assigned by instructor |
| Unit #2 | Family demographics | " |

| | | |
|---|---|---|
| Unit #3 | Family nursing process | " |
| Unit #4 | Family social policy<br>Health disparities related to care of families | " |
| Unit #5 | Genomics and family nursing across the lifespan | " |
| Unit #6 | Health promotion of families | " |
| Unit #7 | Nursing care of families in with specific health needs | " |
| Unit #8 | Nursing care of families in specific health needs | " |
| Unit #9 | Families and public health nursing | " |
| Unit #10 | Nursing care of families in disasters and war | " |
| Unit #11 | Final exam | Comprehensive |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture, discussion, ATI practice exams as applicable to course content and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to integrate nursing knowledge with the humanities, arts and sciences to provide holistic care within the practice of professional nursing.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

| | |
|---|---|
| A | 90% - 100% |
| B | 80% - 89% |
| C | 70% - 79% |
| D | 60% - 69% |
| F | Below 60% |

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN153 Or RN156 ] And [ RN206 Or RN301 Or RN314 ] And [ SS210 ]

*Version #: 11 : May 13, 2014*

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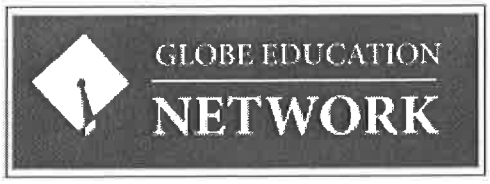



# RN304 Healthcare Issues Across the Lifespan Master Syllabus

## 3 Credit Hours - 30 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisite: RN206. This course focuses on maintaining independence and wellness for individuals across the lifespan. It addresses normal growth and development, normal aging, and consideration for vulnerable populations with special needs, disabilities, and illness and emphasizes the role of the nurse in assisting individuals to maximize independence and quality of life. Students review access to care and referrals to appropriate resources in the context of social justice as a professional value.

**TEXT/SUPPLIES:**

None

**ADDITIONAL RESOURCES:**

ATI learning materials via web access; access (codes supplied by the nursing program).

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Correlate normal aging, disability or illness of individuals as factors determining the need for coordination and management of care in order to maximize independence and quality of life.
2. Analyze factors that may impact the role of the nurse to act as a healthcare advocate for a child, adult or vulnerable population.
3. Investigate the role of the nurse in coordinating and managing care to maximize independence, quality of life and promote health for vulnerable populations.
4. Explore options for healthcare referral and assistance through education, the community, government agencies and health care sources.
5. Discuss the benefit to society for promoting the independence of individuals, the families and populations.
6. Distinguish potential barriers to individuals, families or populations in maintaining independence and wellness within the community.
7. Anticipate the needs of diverse populations and cultures when accessing healthcare.
8. Collaborate with healthcare providers to provide patient-centered care and outcomes.
9. Describe legal and social issues related to access and use of genetic information and technology.
10. Define issues that undermine the right for autonomous, informed genetic and genomic related decision-making and access to services.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Course introduction<br>Social and distributive justice | As assigned by instructor |

| | | |
|---|---|---|
| Unit #2 | Patient advocacy<br>Vulnerable populations | As assigned by instructor |
| Unit #3 | Role of nurse in legislation and policy related to care of the public<br>Health care regulation and barriers to access care<br>• Insurance, Medicare, Medicaid | As assigned by instructor |
| Unit #4 | Ethical issues and genomics<br>Cultural considerations<br>Health disparities | As assigned by instructor |
| Unit #5 | Healthcare issues for infants and children | As assigned by instructor |
| Unit #6 | Healthcare issues for adolescents | As assigned by instructor |
| Unit #7 | Healthcare issues for young adults | As assigned by instructor |
| Unit #8 | Healthcare issues for middle-age adults | As assigned by instructor |
| Unit #9 | Healthcare issues for older adult | As assigned by instructor |
| Unit #10 | Healthcare debate | As assigned by instructor |
| Unit #11 | Referral process and access to care | As assigned by instructor |

**PORTFOLIO ASSIGNMENTS:**

Flicker of interest statement paper
Social justice paper

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture/discussion, guest speakers in seminar format, ATI practice exams as applicable to content, and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Papers /projects/presentations | 30% to 70% |
| Class activities/discussion | 20% to 40% |
| Professional accountability | 2% to 4% |
| Essential Competency Evaluation | P/F Competency |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential V: Healthcare Policy, Finance, and Regulatory Environments | Discuss the implications of healthcare policy on issues of access, equity, affordability, and social justice in healthcare delivery. |
| | |

| | |
|---|---|
| Essential V: Healthcare Policy, Finance, and Regulatory Environments | Discuss the role of advocacy by the nursing profession for consumers of healthcare. |

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to demonstrate values and ethical behaviors reflective of professional nursing practice.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

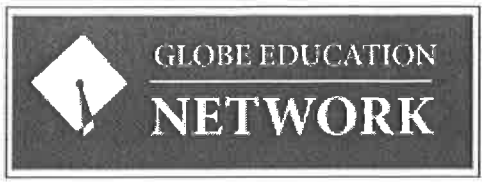
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN206 Or RN301 Or RN314 ]

*Version #: 15 : September 24, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN305 Care of Children Master Syllabus

## 7 Credit Hours - 110 Hours (Lecture 50/Lab 30/ Practicum 30)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN302, RN303, RN304. This course explores the well child and the needs of children requiring health care from infancy through adolescence. Through a family-centered approach, the course addresses health problems in children and the impact of illness on a child and the family. Students correlate normal growth and development with care of the ill child and promote healthy lifestyle strategies in the care of children.

**TEXT/SUPPLIES:**

*Child Health Nursing*, Ball, 3e, Pearson Education, 2013

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Incorporate principles of patient-centered care in the planning, implementation and evaluation of health outcomes for a child Incorporate knowledge of normal growth and development to promotion of wellness and health in children.
2. Correlate knowledge of family theory with the care of the well and ill child within the family.
3. Integrate knowledge from the behavioral, biological and natural sciences in the study of wellness, disease and illness in the pediatric patient.
4. Differentiate between normal physiologic function and pathologic processes in selected diseases of children.
5. Utilize critical thinking and analysis of data to interpret diagnostic and laboratory values in the pediatric patient.
6. Differentiate common diagnostic and treatment options and treatment modalities for each illness/disease process presented.
7. Demonstrate sensitivity to personal and cultural influences within the family structure related to response to illness and treatment beliefs.
8. Transfer knowledge of learning/teaching principles to the needs of children with alterations in health.
9. Incorporate research results regarding family dynamics, disease and care of children into professional practice.
10. Collaborate utilizing an interdisciplinary approach to provide outcome-based care for the family in crisis.
11. Describe common concerns and needs of the family coping with a child's long-term or terminal illness.
12. Intervene to promote the health and safety of vulnerable children.
13. Demonstrate competency in the care of well and ill children and families within clinical settings.
14. Identify means by which nurses may meet the educational and psychosocial needs of families affected by a genetic or genomic condition.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction, culture, growth and development | As assigned by instructor |
| Unit #2 | Nutrition and physical assessment | " |
| Unit #3 | The child and family in community, hospitalization, end of life and pain | " |
| Unit #4 | Health promotion | " |
| Unit #5 | The child with alterations of fluid, electrolyte and immunological systems | " |
| Unit #6 | The child with alterations of eye, ear, nasal, respiratory systems and infections and communicable diseases | " |
| Unit #7 | The child with alterations of cardiovascular and hematological systems | " |
| Unit #8 | The child with alterations of gastrointestinal system and oncological conditions | " |
| Unit #9 | The child with alterations of genitourinary and neurological systems | " |
| Unit #10 | The child with alterations of cognitive, mental health and musculoskeletal systems | " |
| Unit #11 | The child with alterations of skin and endocrine systems | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 30% to 70% |
| Papers/projects | 40% to 50% |
| Class activities/discussion | 15% to 20% |
| Professional accountability points | 2% to 4% |
| Clinical competency | P/F |
| Essential Competency Evaluation | P/F |

Nursing grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential I: Liberal Education for Baccalaureate nursing Practice | Conduct assessments using developmentally and culturally appropriate approaches and techniques. |

| | |
|---|---|
| Essential IX: Baccalaureate Generalist Nursing Practice | |
| Essential III: Scholarship for Evidence-Based Practice<br><br>Essential VII: Clinical Prevention and Population Health<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Analyze data pertaining to a family's structure and function in relation to health needs. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Plan care to assist a family in achievement of patient-centered outcomes. |
| Essential I: Liberal Education for Baccalaureate nursing Practice<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Provide teaching that reflects developmental stage and age of patient. |

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on The Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

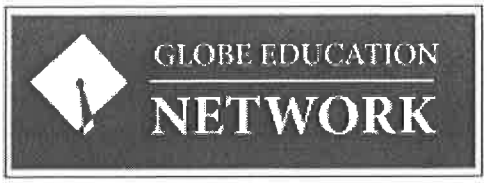
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN302 ] And [ RN303 ] And [ RN304 ]

*Version #: 17 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN404 Holistic End of Life Care Master Syllabus

## 4 Credit Hours - 60 Hours (Lecture 30/Lab 0/Practicum 30)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN302, RN303, RN304. This course focuses on the physical and emotional needs of the patient and family at the end of life. Using an ethical decision-making framework, students explore ethical issues that may arise, such as trans-cultural and spiritual issues, practice issues related to life-support technology, and patient self-determination. The course addresses culturally competent care in the context of belief systems and values of the patient and family. Hospice care and the role of the hospice nurse are integrated into the study of care of the dying and the grieving family.

### TEXT/SUPPLIES:

*Clinical Decision-Making Study Guide for Medical-Surgical Nursing*, Ignatavicius, 7e, Elsevier, 2012

*Clinical Nursing Skills*, Smith, 8e, Pearson Education, 2011

*Gone From My Sight: The Dying Experience*, Karnes, 11e, Barbara Karnes Books, 2008

*Kozier & Erb's Fundamentals of Nursing*, Berman, 9e, Pearson Education, 2010

*Medical-Surgical Nursing: Patient-Centered Collaborative Care*, Ignatavicius, 7e, Elsevier, 2012

*Nursing Care at the End of Life*, Guido, 1e, Pearson Education, 2009

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Integrate scientific theory and research based knowledge into holistic care of the dying patient across the lifespan.
2. Advocate for the belief systems and values of the dying patient to promote a peaceful death.
3. Integrate cultural sensitivity and awareness into care of the dying patient and the grieving family.
4. Facilitate patient and family education to make quality-of-life and end-of-life decisions.
5. Incorporate ethical decision-making processes and patient advocacy into professional practice regarding end-of-life issues.
6. Synthesize the role of the hospice nurse to promote a peaceful and dignified death as well as care for a grieving family.
7. Explore processes to support ethical, non-coercive decision making by older adults and/or families/caregivers for initiating advance directives, and implementing end of life care.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | History of hospice and palliative care | As assigned by instructor |
| Unit #2 | Spirituality and culture in relationship to death and dying | " |
| Unit #3 | Management of distressing symptoms<br>Pain management | " |
| Unit #4 | The dying process | " |
| Unit #5 | Grief: What is it? | " |
| Unit #6 | Ethical issues regarding end of life decisions | " |
| Unit #7 | Legal issues regarding end of life decisions | " |
| Unit #8 | End of life simulation | " |
| Unit #9 | Current issues and topics in end of life care | " |
| Unit #10 | Current issues and topics in end of life care | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture, discussion, simulation, ATI practice exams as applicable to course content, case studies and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Papers /projects/presentations | 20% to 50% |
| Quizzes/exams | 40% to 80% |
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F |
| Essential Competency Evaluation | P/F |
| Professional accountability | 2% to 4% |

Nursing grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VIII: Professionalism and Professional Values<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Implement patient and family care at end-of-life with sensitivity and respect for cultural preferences. |
| | |

| | |
|---|---|
| Essential III: Professionalism and Professional Values<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Implement evidence-based nursing interventions for symptom management and comfort. |
| Essential V: Healthcare Policy, Finance, and Regulatory Environments | Demonstrate an understanding of health care policy and regulatory processes related to end-of-life care. |

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to advocate for the patients and consumers of health care within health care delivery systems.

**CLINICAL COMPETENCIES:**

The student will apply learning with emphasis on the individual and family at end of life in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN302 And RN303 And RN304 ]

*Version #: 14 : May 13, 2014*

**Globe University - Minnesota School of Business**
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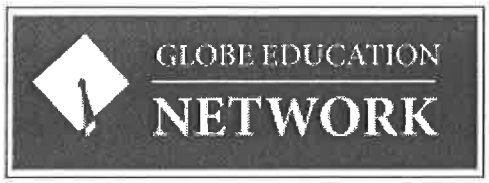



# RN306 Care of the Child Bearing Family Master Syllabus

## 7 Credit Hours - 110 Hours (Lecture 50/Lab 30/ Practicum 30)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN302, RN303, RN304. This course covers care of the child bearing family, from preconception through postpartum and assessment and care of the newborn. It emphasizes promoting healthy pregnancy and birth within a family-centered care environment. It also addresses high-risk pregnancy, pregnancy complications, and nursing care of the high-risk newborn. Students apply family nursing theory as they care for families with new children.

**TEXT/SUPPLIES:**

*Maternity and Women's Health Care*, Lowdermilk, 10e, Elsevier, 2011

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Apply concepts of family-centered care to the child-bearing family.
2. Synthesize theoretical knowledge of family theory with expected outcomes for a family's psychological and physical adaptation to pregnancy.
3. Integrate concepts of heath promotion with nursing care that promotes healthy pregnancy and fetal growth.
4. Differentiate assessment of normal and high-risk pregnancy, including factors that contribute to development of high –risk pregnancies.
5. Demonstrate sensitivity to personal and cultural beliefs regarding child-bearing.
6. Integrate knowledge of pathophysiology of disease that can result in complications in pregnancy.
7. Incorporate knowledge of family planning, stages of pregnancy, and labor and delivery alternatives into family-centered outcomes of care.
8. Assess a newborn for normal growth and development and plan care to aid parent-child bonding.
9. Identify characteristics of a high-risk newborn and correlate family-centered care principles to the family of a high-risk newborn.
10. Analyze the social and economic impact to the family with a high-risk newborn.
11. Integrate knowledge of the needs of a high-risk infant to coordinate and manage outcomes of care.
12. Demonstrate competency in assessment, planning, implementing and evaluating outcomes of care for the child-bearing family and infant in the clinical setting.
13. Discuss the process for assessment of a patient/family's understanding of genetic and genomic information.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction to course and clinical requirements | As assigned by instructor |
| Unit #2 | The postpartal family | " |
| Unit #3 | The postpartal family at risk | " |
| Unit #4 | The normal newborn | " |
| Unit #5 | Conception and fetal development | " |
| Unit #6 | The intrapartal family | " |
| Unit #7 | The antepartal family at risk | " |
| Unit #8 | The newborn at risk | " |
| Unit #9 | Women's health | " |
| Unit #10 | Simulation related to unit content | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation exercises, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 30% to 70% |
| Papers/projects | 40% to 50% |
| Class activities/discussion | 15% to 20% |
| Professional accountability points | 2% to 4% |
| Clinical competency | P/F |
| Essential Competency Evaluation | P/F |

Nursing Grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential IX: Baccalaureate Generalist Nursing Practice | Implement holistic, family-centered care that reflects respect for patient and/or family preferences. |
| Essential VII: Clinical Prevention and Population Health | Use evidence-based practices to guide culturally appropriate health teaching for caregivers. |
| | |

| | |
|---|---|
| Essential VII: Clinical Prevention and Population Health | Recognize data from a family health history that may impact future health problems. |

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on The Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN302 ] And [ RN303 ] And [ RN304 ]

*Version #: 12 : December 16, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN307 Care of the Critically Ill Patient Master Syllabus

## 4 Credit Hours - 50 Hours (Lecture 30/Lab 20)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN302, RN303, RN304. This course focuses on the unique health care needs of the critically ill patient and the impact of illness on the family and community. Students correlate pathophysiology with assessment and evaluate responses to interventions for patients requiring intensive nursing and medical care. Students further develop the roles of educator, collaborator, and advocate to care for patients and families in crisis.

**TEXT/SUPPLIES:**

*Introduction to Critical Care Nursing*, Sole, 6e, Elsevier, 2012

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Correlate the impact of care for the critically ill patient to family dynamics.
2. Integrate knowledge of selected pathophysiology with assessment, planning, implementation and evaluation of outcomes of care for the critically ill patient.
3. Incorporate high acuity treatment modalities and cultural considerations into a holistic, patient-centered plan of care.
4. Distinguish the education needs of critically ill patients and families and incorporate learning strategies into a collaborative, interdisciplinary teaching plan.
5. Interface high acuity technology with caring behaviors in the critical care setting.
6. Integrate research results into assessment, planning, implementation and evaluation of outcomes of care for the critically ill patient.
7. Intervene as an advocate for the patient and family for informed decision-making.
8. Engage in a Career Development activity: Examine personal and professional values relating to assimilation of the role of the professional nurse in the critical care setting.
9. Discuss resource allocation issues and stress to the health care system as they relate to care of the critically ill.
10. Integrate the roles of coordinator and manager of care with designer of care for the critically ill patient.
11. Differentiate genetic /genomic causes for specific chronic diseases and illnesses and understand the implications for care in a critically ill patient.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction to intensive care nursing<br>Multidisciplinary care and pharmacology | As assigned by instructor |
| Unit #2 | Respiratory and ventilator care | " |
| Unit #3 | Cardiac foundation | " |
| Unit #4 | Hemodynamics | " |
| Unit #5 | Hemodynamics continued | " |
| Unit #6 | Coronary artery bypass | " |
| Unit #7 | Running a code | " |
| Unit #8 | Multisystem failure | " |
| Unit #9 | Multisystem failure continued | " |
| Unit #10 | Death and dying and death investigation<br>Ethics in ICU | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, nursing skills/interventions demonstrations, simulation lab exercises and ATI practice exams.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams | 40% to 80% |
| Papers/projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Simulation lab competency | P/F competency |
| Professional accountability points | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN302 ] And [ RN303 ] And [ RN304 ]

*Version #: 13 : March 17, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN401 Behavioral Health Care Master Syllabus

## 7 Credit Hours - 110 Hours (Lecture 50/Lab 0/Practicum 60)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN302, RN303, RN304. This course explores care of individuals, families, and communities experiencing alterations in mental health. Students investigate implications of living with an altered pattern of behavior and the impact on the family and community. The course emphasizes therapeutic use of self in establishing nurse-patient relationships, along with the nurse's role in collaborating with an interdisciplinary team to promote mental health.

### TEXT/SUPPLIES:

*Manual of Psychiatric Nursing Care Planning*, Varcarolis, 5e, Elsevier, 2014

*Psychiatric Mental Health Nursing: Concepts of Care*, Townsend, 8e, F.A. Davis, 2014

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Incorporate theoretical knowledge related to behavioral health and illness to patient-centered care outcomes.
2. Integrate knowledge of growth and developmental with influence on mental health or illness in individuals and families.
3. Recognize cultural influences in promoting mental health or illness and incorporate cultural competence into mental health assessment and evaluation.
4. Integrate "therapeutic use of self" within patient, family and group interactions.
5. Incorporate ethical guidelines and decision-making in provision of care, advocating for, and protecting the rights of patients with mental health needs.
6. Synthesize knowledge of legal issues and regulations relating to the care of clients with mental health needs into professional nursing role.
7. Promote public policy leading to awareness and promotion of mental health care.
8. Describe the mechanism of dysfunction for each presented mental or behavioral health disorder.
9. Integrate and manage therapy and treatment options with assessment of physical and psychological symptoms when planning, implementing and evaluating outcomes of patient-centered care.
10. Incorporate evidenced-based research practices into behavioral health venues.
11. Demonstrate integration of interdisciplinary behavioral health care principles within competent, sensitive care of the patient in the clinical setting.
12. Recognize the complex interaction of acute and chronic co-morbid physical and mental conditions and associated treatments common to older adults.

13. Identify actual or potential physical or mental mistreatment and/or self-neglect in older adults and refer appropriately.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Mental health /mental illness: Historical and theoretical concepts | As assigned by instructor |
| Unit #2 | Stress adaptation in mental health and mental illness<br>Theoretical models of personality development | " |
| Unit #3 | Ethical and legal issues in mental health<br>Cultural and spiritual concepts<br>Relationship development<br>Therapeutic communication | " |
| Unit #4 | Concepts of psychobiology and psychopharmacology | " |
| Unit #5 | Nursing Process in PMHN<br>Therapeutic groups and intervention with families | " |
| Unit #6 | Milieu Therapy in mental health care<br>Behavioral and Cognitive Therapy | " |
| Unit #7 | Mental health disorders related to developmental age groups | " |
| Unit #8 | Mental health disorders<br>Schizophrenia – psychotic disorders<br>Mood disorders<br>Anxiety disorders | " |
| Unit #9 | Mental health disorders<br>Somatoform and dissociative disorders<br>Issues related to sexuality<br>Eating disorders<br>Personality disorders | " |
| Unit #10 | Mental health and aging<br>Concepts of abuse and neglect<br>Community mental health nursing<br>Forensic nursing<br>The bereaved Individual | " |
| Unit #11 | Final exam | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture, class discussion, simulation, journaling, ATI practice exams, and clinical experiential learning.

**MODE OF INSTRUCTION:**

May be taught residentially .

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |

| | |
|---|---|
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F Competency |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

| | |
|---|---|
| A | 90% - 100% |
| B | 80% - 89% |
| C | 70% - 79% |
| D | 60% - 69% |
| F | Below 60% |

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own

words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN302 ] And [ RN303 ] And [ RN304 ]

*Version #: 18 : March 17, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN403 Nursing Research and Evidence-Based Practice Master Syllabus

## 3 Credit Hours - 30 Hours (Lecture)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: CM320, NS305, RN302, RN303, RN304. This course analyzes principles of research that improve patient outcomes and health of populations. Topics include research design and methodologies, ethics, protection of subjects, and the role of the nurse as a participant in research. Students critically analyze examples of nursing research and correlate findings with evidence of best practice in the care of individuals, families, and populations.

### TEXT/SUPPLIES:

*Understanding Nursing Research: Building and Evidence-Based Practice*, Grove, 6e, Elsevier, 2014

None

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Investigate opportunities for the baccalaureate nurse to participate in research, promote best practices and positively affect health care policy.
2. Compare and contrast research design and methodologies and apply knowledge in the critical analysis of a research problem and study.
3. Discuss the ethical and legal implications for nursing inherent to using human subjects in a research study.
4. Correlate statistical analysis of research findings with patient/population outcomes.
5. Utilize critical analysis of research findings to guide professional practice.
6. Evaluate sources of evidence and clinical practice guidelines for a patient whose care involves genetic or genomic healthcare.

### COURSE OUTLINE:

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Discovering nursing research | As assigned by instructor |
| Unit #2 | Quantitative research process | " |
| Unit #3 | Qualitative research process | " |
| Unit #4 | Research problems, purposes, hypothesis | " |
| | | |

| | | |
|---|---|---|
| Unit #5 | Research frameworks, literature reviews | " |
| Unit #6 | Ethics and legal issues in research | " |
| Unit #7 | Populations and samples, measurement, statistical analysis | " |
| Unit #8 | Research and implications for practice | " |
| Unit #9 | Role of the BSN in research | " |
| Unit #10 | Building an evidence-based practice | " |
| Unit #11 | Final exam | " |

**PORTFOLIO ASSIGNMENTS:**

Researchable problem paper

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture, discussion, ATI practice exams as applicable to course content and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to apply research based knowledge from nursing and the sciences as a foundation for evidenced based practice maintaining, restoring and optimizing health.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ CM320 And NS305 And RN302 And RN303 And RN304 ]

*Version #: 10 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**

# RN408 Community Health Nursing Master Syllabus

## 7 Credit Hours - 130 Hours (Lecture 40/Lab 0/Practicum 90)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN305, RN306, RN307, RN401, RN403, RN404. This course expands the focus of health care to the community and populations. Students assess and affect the health of individuals, families, and communities through participation in home visits, health screening, health promotion clinics, and education activities. The course addresses environmental health and safety, epidemiology, and communicable disease control affecting health of populations. Students review critical analysis of research and the role of the nurse as a change agent in forming public health policy.

### TEXT/SUPPLIES:

*Public Health Nursing: Population-Centered Health Care in the Community*, Stanhope, Revised 8e, Elsevier, 2013

### ADDITIONAL RESOURCES:

- ATI learning materials via web access; access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Research and define the concept of community as a recipient of nursing care.
2. Analyze the relationships between health, healthcare and community health nursing.
3. Explore the structure, function and interrelationships of community health nursing, community-based nursing and public health nursing.
4. Differentiate the roles of the professional nurse in community health nursing.
5. Integrate essentials of population focused care with assessment of the environment, community health problems, and epidemiology to promote health.
6. Analyze the influence of health policy on community health and nursing practice.
7. Interpret the role of professional nursing in impacting health care reform and policy making.
8. Integrate advocacy for public health into nursing role that promotes and protects the health of the public.
9. Discuss how politically empowered nurses may function as change agents to promote health care.
10. Coordinate and manage care for individuals, families and groups in various community settings.
11. Integrate transcultural competencies into nursing care within community settings.
12. Incorporate community assessment, analysis, and outcome planning into nursing practice to promote the health of populations.
13. Assess community resources for genetic and genomic information and technologies.

### COURSE OUTLINE:

| Units | Topics/Activities | Reading |
|---|---|---|

| | | |
|---|---|---|
| Unit #1 | The concept of community health nursing/public health nursing | As assigned by instructor |
| Unit #2 | Population-focused health care | As assigned by instructor |
| Unit #3 | Epidemiology: The study of disease, injury, and death in populations<br>Infectious diseases: Past and present challenges | As assigned by instructor |
| Unit #4 | Community health nursing: The current context<br>The US health care system and community empowerment | As assigned by instructor |
| Unit #5 | Community health nursing:The economic, environmental and global context | As assigned by instructor |
| Unit #6 | Community health nursing: Nursing beginnings and theoretical foundations | As assigned by instructor |
| Unit #7 | Community health nursing: Advocacy and policy development | As assigned by instructor |
| Unit #8 | Approaches to community health nursing: Case-management and health promotion, disease prevention | As assigned by instructor |
| Unit #9 | Care of special populations | As assigned by instructor |
| Unit #10 | Community Assessment | As assigned by instructor |
| Unit #11 | Final exam | As assigned by instructor |

**PORTFOLIO ASSIGNMENTS:**

Applied learning reflection assignment
Community assessment paper

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, simulation exercises, ATI practice exams, and clinical experiential learning. This course uses service learning assignments.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Service learning reflection journal | P/F Competency |
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F |
| Essential Competency Evaluation | P/F |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

***Essential Competencies Evaluated in this Course:**

*Competencies in this course meet requirements, upon graduation and licensure, to register with the Board of Nursing for Public Health Nurse Certification.

| Essential | Competency Description |
|---|---|
| Essential VII: Clinical Prevention and Population Health | Assess the health, healthcare, and emergency preparedness needs of a population. |
| Essential VII: Clinical Prevention and Population Health | Identify the incidence, distribution, and control of disease in a population, as well as risk factors and environmental factors related to communities. (MBN 6316.0100 A.) |
| Essential VII: Clinical Prevention and Population Health I | Identify populations at high risk of illness, disability, premature death, or poor recovery. (MBN 6316.0100 B.) |
| Essential VII: Clinical Prevention and Population Health I | Demonstrate clinical judgment necessary to collaborate and intervene with a plan for high-risk populations. (MBN 6316.0100 C.) |
| Essential VII: Clinical Prevention and Population Health I | Evaluate the effect of interventions on the health status of a population. (MBN 6316.0100 D.) |
| Essential VII: Clinical Prevention and Population Health I | Recognize community services, institutional resources, and other health care providers available to populations based on need. (MBN 6316.0100 E.) |

**LEARNING OUTCOME ASSESSMENT:**

In this class students will be assessed on their ability to use knowledge of health promotion, risk reduction and disease prevention in providing holistic care to individuals, families, groups and communities.

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

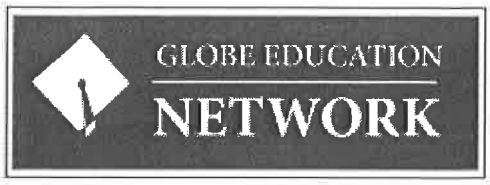
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN305 ] And [ RN306 ] And [ RN307 ] And [ RN401 ] And [ RN403 ] And [ RN404 ]

*Version #: 15 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN405 Leadership and Management in Nursing Master Syllabus

## 7 Credit Hours - 110 Hours (Lecture 50/Lab 0/Practicum 60)

### COURSE DESCRIPTION AND PREREQUISITE(S):

Prerequisites: RN305, RN306, RN307, RN401, RN403, RN404. This course analyzes the role of the professional nurse as a manager and leader in health care systems and as a member of a profession. Students consider principles of management theory, leadership theory, conflict resolution, negotiation, and group process skills as they evaluate the role of the nurse as a designer, manager, and coordinator of care. The course also addresses methods to evaluate the quality of nursing care and analyze cost-effective health care delivery systems.

### TEXT/SUPPLIES:

*Leadership and Nursing Care Management*, Huber, 5e, Elsevier, 2013

*New Leadership Challenge*, Grossman, 4e, F.A. Davis, 2012

### ADDITIONAL RESOURCES:

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

### OBJECTIVES:

Upon completion of this course you will be able to:

1. Distinguish between leadership, followership and management roles of the professional nurse.
2. Correlate the impact of nursing leadership with development of institutional and health care policy.
3. Synthesize knowledge of organizational structure, culture, climate and mission with nursing care delivery systems and management theory.
4. Engage in a Career Development activity: Employ leadership theory and skills to efficiently and effectively manage health care units, organizations, and teams.
5. Incorporate characteristics of a leader through life-long learning, participation in professional organizations, and by demonstrating accountability for practice and leadership decisions.
6. Apply ethical decision-making principles and professional codes of conduct to patient and staff situations requiring leadership intervention.
7. Coordinate and manage the health care of individuals across the lifespan utilizing principles and knowledge of interdisciplinary models of care delivery and case management.
8. Integrate qualities and behaviors that contribute to effective leadership into professional nursing role within a variety of clinical settings.
9. Integrate advocacy for professional standards of practice using organizational and political processes.

10. Integrate use of ethical principles and advocacy when deliberating genetic/genomic issues within organizational policy or in planning care.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Introduction<br>Current health care environment<br>Leadership, followership, and management: theories, principles, and research | As assigned by instructor |
| Unit #2 | Change and innovation<br>Organizational change<br>Planned change process<br>Nurse leader as change agent: empowerment | " |
| Unit #3 | Power and conflict<br>Politics: the art of influence<br>Health care policy and political action | " |
| Unit #4 | Working effectively with groups<br>Team building<br>Motivation<br>Conflict management | " |
| Unit #5 | The health care system<br>Organizational structure<br>Organizational communication and infomatics<br>Culture and climate<br>Strategic planning<br>Quality improvement | " |
| Unit #6 | Financial management<br>Budgeting<br>Resource management<br>Staffing and scheduling | " |
| Unit #7 | Stress and time management<br>Critical thinking<br>Decision making<br>Shared governance | " |
| Unit #8 | Effective delegation<br>Legal and ethical issues | " |
| Unit #9 | Cultural and generational issues<br>Workforce diversity<br>Staff development and performance appraisal | " |
| Unit #10 | Nursing future<br>Professional and lifelong learning<br>Career development | " |
| Unit #11 | Final exam | " |

**PORTFOLIO ASSIGNMENTS:**

Applied learning reflection assignment
Leadership organizational need assessment project and poster presentation

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation/group projects, lecture/discussion, simulation exercises, ATI practice exams, clinical experiential

learning, and applied learning techniques. This course uses workplace application or service-learning as a form of applied learning.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 40% to 80% |
| Papers /projects/presentations | 20% to 50% |
| Class activities/discussion | 10% to 30% |
| Clinical competency | P/F |
| Essential Competency Evaluation | P/F |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety | Apply leadership concepts, skills, and decision making when delegating to the healthcare team. |
| Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate professional oversight and accountability for care that contributes to safe and quality patient outcomes. |
| Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety | Participate in the assessment and development of a plan to support system improvement and/or change. |

**LEARNING OUTCOME ASSESSMENT:**

In this class students will be assessed on their ability to incorporate leadership skills into the practice of professional nursing.

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

| | |
|---|---|
| A | 90% - 100% |
| B | 80% - 89% |
| C | 70% - 79% |
| D | 60% - 69% |
| F | Below 60% |

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

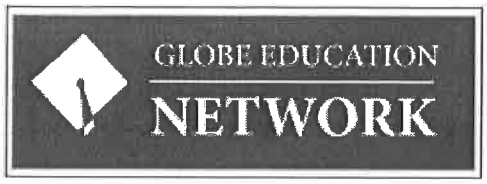
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN305 And RN306 And RN307 And RN401 And RN403 And RN404 ]

*Version #: 6 : May 13, 2014*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN409 Nursing Within a Global Community Master Syllabus

## 3 Credit Hours - 30 Hours (Lecture)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN405 and RN408. This course addresses the global environment as a context for health care and the role of nursing in promoting world health. Topics include the effects of disease transmission, health policy, bioterrorism, natural disasters, and economics on interconnected populations and on public health. The course addresses disaster planning, emergency response plans, and triage principles, and explores examples in which nursing advances world health by promoting collaboration and sharing of research between nations.

**TEXT/SUPPLIES:**

*Critical Issues in Global Health*, Koop, 1e, John Wiley & Sons, 2002

**ADDITIONAL RESOURCES:**

ATI learning materials via web access (codes supplied by the nursing program)

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Engage in a Career Development activity: Incorporate knowledge of the global environment in which health care is provided into nursing practice.
2. Synthesize the impact of natural or unnatural disasters on the scarce resources of nursing worldwide.
3. Engage in interdisciplinary collaboration to implement community disaster and emergency preparedness plans into institutional and public policy.
4. Critically examine the effects of health care policy on world health and the role of professional nursing to encourage legislation and policy consistent with advancement of health care.
5. Incorporate cultural competence when addressing issues of world health and disease transmission.
6. Analyze nursing research data supporting international collaboration to promote world health.
7. Analyze the impact of information technology in connecting health organizations, delivery systems, and international public health venues.
8. Analyze the importance of supplying genetic and genomic information and services based on culture, religion, knowledge level, literacy, and preferred language.
9. Discuss the effect of genetic and genomic education on disease transmission and world health.

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | The concept of global health care | As assigned by instructor |
| Unit #2 | World health issues | " |
| Unit #3 | Health care policy from a global perspective | " |

| | | |
|---|---|---|
| Unit #4 | Investigation of nursing research related to world health issues | " |
| Unit #5 | Relationship of cuture and beliefs to health locally and globally | " |
| Unit #6 | Socioeconomic structure and health | " |
| Unit #7 | Disaster planning and emergency preparedness | " |
| Unit #8 | Pandemics / Center for Disease Control | " |
| Unit #9 | Holistic care during crisis or disaster: Locally or abroad | " |
| Unit #10 | Nursing across nations and continents: What is nursing doing to promote world health? | " |
| Unit #11 | Implications for professional practice at the baccalaureate level | " |

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture, discussion, ATI practice exams as applicable to course content and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams | 5% to 10% |
| Papers /projects/presentations | 40% to 70% |
| Class activities/discussion | 15% to 30% |
| Essential Competency Evaluation | P/F |
| Professional accountability | 2% to 4% |

Nursing scores are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|
| Essential VIII: Professionalism and Professional Values<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate an understanding of the participation role of nursing in emergency preparedness and disaster response as well as the risks posed to self and patients. |

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

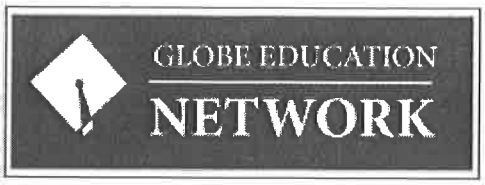
**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN405 ] And [ RN402 Or RN408 ]

*Version #: 8 : March 17, 2015*

**Globe University - Minnesota School of Business**
**Broadview University - Institute of Production and Recording**




# RN413 Nursing Internship/Professional Role Development Master Syllabus

## 7 Credit Hours - 150 Hours (Lecture 30/Lab 0/Practicum 120)

**COURSE DESCRIPTION AND PREREQUISITE(S):**

Prerequisites: RN404, RN405. This course prepares students for entry into professional practice. In an internship experience, students integrate professional nursing essentials and accountability with independent practice. Through a self-reflective process, students formulate goals for lifelong learning and professional development.

**TEXT/SUPPLIES:**

*Nursing Today: Transition and Trends*, Zerwekh, 8e, Elsevier, 2014

None

**ADDITIONAL RESOURCES:**

- ATI learning materials via web access (codes supplied by the nursing program).
- Neehr Perfect electronic health records software is utilized in this course.

**OBJECTIVES:**

Upon completion of this course you will be able to:

1. Integrate professional values with internship opportunities to add to the depth and breadth of nursing role development.
2. Develop competency in the delivery of nursing care leading to independent action and thoughtful deliberation of patient-centered outcomes.
3. Incorporate analysis of research findings with implementation of best practice within the roles of the professional nurse.
4. Engage in a Career Seeking activity: Demonstrate insight and self-awareness in articulation of knowledge, competency and readiness to apply principles of patient-centered care as a graduate nurse.
5. Synthesize scientific principles, professional values, core competencies and core knowledge essential to role development of the baccalaureate nurse within each professional interaction in various clinical settings

**COURSE OUTLINE:**

| Units | Topics/Activities | Reading |
|---|---|---|
| Unit #1 | Course introduction/internship criteria<br>Effective communication as a new graduate<br>Clinical dialogue and discussion | As assigned by instructor |
| | | |

| | | |
|---|---|---|
| Unit #2 | ATI: comprehensive predictor and critical thinking<br>NCLEX-RN preparation and review information<br>Role transition: from student to graduate | " |
| Unit #3 | Professional socialization and survival as a nurse<br>Clinical dialogue and discussion | " |
| Unit #4 | Collaboration & conflict resolution for nurses<br>Clinical dialogue and discussion | " |
| Unit #5 | Legal issues for the new graduate<br>Clinical dialogue and discussion | " |
| Unit #6 | ATI comprehensive predictor exam | " |
| Unit #7 | Followship to leadership<br>Clinical dialogue and discussion | " |
| Unit #8 | Ethical considerations for the new graduate nurse<br>Clinical dialogue and discussion | " |
| Unit #9 | Commitment to life-long learning within the nursing profession<br>Clinical dialogue and discussion | " |
| Unit #10 | MBN licensure requirements<br>Clinical dialogue and discussion | " |
| Unit #11 | Capstone evaluation | " |

**PORTFOLIO ASSIGNMENTS:**

Capstone paper related to attainment of program expected outcomes

**INSTRUCTIONAL METHODS:**

During this course, your instructor will employ a variety of instructional methods including class participation, group projects, lecture, discussion, ATI practice exams as applicable to course content and case studies.

**MODE OF INSTRUCTION:**

May be taught residentially, online, or in a hybrid format.

**EVALUATION METHODS:**

Your grade will be determined as follows:

| | |
|---|---|
| Quizzes/exams/ATI proctored exam | 10% to 15% |
| Papers/projects | 40% to 80% |
| Class activities/discussion | 15% to 20% |
| Professional accountability points | 2% to 4% |
| Clinical competency | P/F at 80% competency |
| Essential Competency Evaluation | P/F |

Nursing Grades are not rounded up when calculating grades.

**Essential Competencies Evaluated in this Course:**

| Essential | Competency Description |
|---|---|

| | |
|---|---|
| Essential IX: Baccalaureate Generalist Nursing Practice | Manage care to maximize health, independence, quality of life and/or peaceful end-of-life for a group of patients. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Implement caring, holistic, patient-centered, culturally relevant care that reflects integration of human growth and development, pathophysiology, pharmacology, medical management and nursing management across the health-illness continuum, across the lifespan and within diverse healthcare settings. |
| Essential IX: Baccalaureate Generalist Nursing Practice | Demonstrate competency in the thirteen (13) Individual Student Learning Outcomes, supported by evidence, through examples of patient care interactions from clinical preceptorship. |

**LEARNING OUTCOME ASSESSMENT:**

In this class, students will be assessed on their ability to:

1. Collaborate with patients, health care providers and other members of the interdisciplinary team to assess, plan, implement and evaluate patient focused outcomes.
2. Demonstrate self-awareness in identifying goals for life-long professional development.

**CLINICAL COMPETENCIES:**

The student will apply learning in various health care settings.

- Based on the Essentials of Baccalaureate Education for Professional Nursing Practice (2008)
- Based on Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (2010)
- Based on Essentials of Genetic and Genomic Nursing: Competencies, Curricula Guidelines, and Outcome Indicators, 2nd Edition (2008)
- Essential Competencies defined by the program
- Nursing program goals and expected program outcomes

A student cannot receive a passing grade in this course without successfully completing each required competency.

**RESEARCH METHODS:**

Library research support is available for this class if necessary. See Campus Librarian for details.

**ASSESSMENT CRITERIA:**

A 90% - 100%

B 80% - 89%

C 70% - 79%

D 60% - 69%

F Below 60%

Nursing students must receive a final grade of C (70%) or higher to earn credit for this course.

**OUT-OF-CLASS LEARNING ACTIVITIES AND ASSIGNMENTS:**

Students should expect required assignments outside of the classroom hours identified on this syllabus. This time is used to prepare for class, to reinforce material already presented, and to advance skills. For each lecture (ACICS)/didactic (ACCSC) hour, two hours of outside work is expected.

**INSTRUCTOR ADDENDUM:**

The course addendum is an integral part of this syllabus and should be consulted for specific class guidelines; please review this information carefully.

**ACADEMIC DISHONESTY:**

Academic dishonesty includes cheating on tests or assignments, submitting work completed by others, using the same work to fulfill requirements for multiples classes or plagiarizing. Plagiarism is defined as committing literary theft by attempting to pass off the ideas or words of another as one's own without crediting the source (http://www.merriam-webster.com/dictionary/plagiarize). All completed work must be in the student's own words and must cite the source of the idea where applicable.

Results of an academic dishonesty finding:

Any student who acts dishonestly will be required to meet with the dean of students and will be subject to one of the following actions:

A grade of zero for the work in question

A failing grade for the course

Expulsion from school

Multiple findings of academic dishonesty will lead to increasing levels of sanctions up to and including permanent expulsion from school. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in the student handbook and in the school catalog.

**POLICIES:**

Please refer to the current edition of the student handbook to view the Student Disability Policy as well as the Academic Freedom/Academic Integrity Policy

Sequence Rules for Internal Use Only: [ RN404 ] And [ RN405 ]

## I. Policy for Admission

a. Applicants who have taken college-level coursework must have:
   i. A cumulative GPA of 2.75 or greater for all college-level coursework taken.
   ii. Official transcripts from all institutions attended.
   iii. A cumulative GPA of 2.75 or better maintained from time of acceptance to the program to the start of first quarter nursing courses.
b. Completed within the last five years, with a grade of C or better, high school or college-level general biology, or the equivalent, with a lab; and high school or college-level general chemistry, or the equivalent, with a lab.
c. TEAS Assessment Test
   i. All applicants must take the TEAS (Test of Essential Academic Skills). The placement results in the four areas of reading, math, science and English are reviewed based on the Adjusted Individual Total Preparedness Level achieved by the applicant (Exemplary, Advanced, Proficient, Basic, and Developmental). Two weeks after the initial TEAS exam, a prospective student may take one section or the exam in its entirety for a second attempt.
   ii. All applicants must show proof of meeting nursing assistant competency by documentation of one of the following:
      1. Completion within the last five years, with a passing grade, of a federally approved nursing assistant (NA) class.
      2. Experience within the last five years as a nursing assistant, with documentation of experience on letterhead from the employer, including a detailed job description that verifies skills.
      3. A passing grade on the Nursing Assistant Test-Out exam within the last five years.
      4. Current listing on the Nursing Assistant Registry in Minnesota/ Wisconsin.
d. Personal Goal Statement:
   i. Statement of the applicant's educational and career goals as they relate to the profession of nursing at the baccalaureate level of practice.
   ii. One to two pages, typed and double-spaced.
e. Two letters of recommendation (from professional associates).
f. Transcripts from all institutions attended.

All applications submitted will be reviewed by the dean of nursing and a committee for consideration of acceptance to the program. The nursing department reserves the right to select those with the best qualifications from applicants who meet the minimum requirements. Applicants will not be accepted to the BSN program without approval by the dean of nursing.

A petition to appeal for exceptions to the admission criteria may be made to the dean of nursing under certain mitigating conditions. The appeal is to be submitted in writing, using the appropriate college form and with complete accompanying support documents, prior to the deadline for applications for the next acceptance period. The dean of nursing will review the appeal and make a

determination. The applicant will be notified of the decision within two weeks of submission of the appeal. The decision of the dean of nursing is final and may not be appealed further.

## II. PROGRAM PROGRESSION & GRADUATION REQUIREMENTS

### 1. Background Study

Minnesota and Wisconsin law requires health care facilities, licensed by the Minnesota Department of Health/Wisconsin Department of Safety and Professional Services, have a background study conducted by the state for individuals who provide direct contact services to patients and residents in their facilities and programs. These studies are required each year. Students will complete the study during initial program orientation and annually in January or July through graduation. The nursing project coordinator will facilitate the study and maintain the results in the student nursing file.

The nursing program is required to provide documentation to all clinical partners that students, participating in a clinical course within their facility, are cleared to provide care without restrictions.

- An individual who is disqualified as a result of the study, and whose disqualification is not set aside by the Commissioner of Health, will not be permitted to participate in any clinical activities in a Minnesota/Wisconsin licensed health care facility.
- A student who refuses a background study, or is disqualified as a result of the study, and whose disqualification is not set aside by the Commissioner of Health, will not be able to enroll in, or complete a course that has clinical experience as a component for successful completion. The student will be unable to successfully complete the requirements of the course/s and the program and may be exited from the program.

Students who are disqualified, or fail to participate in the background study process, will be counseled to 1) drop registration prior to the start of the quarter or 2) withdraw from a course requiring clinical experience, before the date on the college calendar indicating the last day to drop or withdraw. If it is past this date, or a student chooses not to withdraw, the student will receive a grade of "F" for the course. If the student refuses to participate in the background study, the clinical facility will refuse to accept the student.

### 2. HIPPA Requirement

Students are required to complete and sign a Nursing Program Confidentiality Form prior to their first clinical experience. Students should retain a copy. The original will be placed in the nursing program student file.

Students are required to complete HIPPA education in RN152 Nursing Foundations as preparation for clinical. Information is included in the course syllabus and addendum.

Prior to beginning any clinical experience in the nursing program, students may be required to complete facility specific Health Insurance Portability and Accountability Act (HIPPA) training according to policy/procedure of the facility.

3. In order to progress within the nursing curriculum and qualify for graduation with a Bachelor of Science in Nursing, the student must meet the following requirements:

   a. Obtain a minimum GPA of 2.0 on all course work each quarter

b. Earn grades of "C" or greater in all general education, medical technology and nursing courses. A grade less than "C" constitutes a failure and will be reflected on the college transcript as a "D*" or "F", depending on grade earned.

4. **Nursing program students will not be allowed to continue in the nursing program if they have failed or withdrawn from:**

   **a. the same nursing course more than once.**
   **b. two different RN courses over more than one quarter (including a course previously failed and repeated with a passing grade).**

   Refer to "Conditions for Exit" from the Nursing Program in this manual for complete information.

5. The deadline for completing all nursing course requirements is the last day of the quarter unless specified differently in course addendum or quarter calendars.

6. Incompletes must be completed by the last day of late registration of the subsequent quarter per college policy. An incomplete grade not completed by the deadline will be changed to an "F" and will be included in the cumulative grade point average.

7. Completion of clinical hours may not be extended beyond the date given at the beginning of each quarter and per course addendum. Incompletes will not be given due to absence days in a clinical rotation.

8. Competency test-out requirements must be completed within program specifications and by the deadline given in course addendum and quarter calendars.

9. Students must adhere to the Standards of Conduct contained in the Nursing Program Resource Manual (Exhibit A) and College Conduct Policy as stated in the College Catalog (Exhibit B) and Student Handbook/Planner (Exhibit C).

10. Students with Disability Statement – The Nursing Program follows the Students with Disability Policy as stated in the College Catalog (Exhibit D).

11. All components of a nursing course are required to be completed in order to determine a final course grade. **Not completing a course requirement will result in automatic failure of the course (refer to individual course syllabi and addenda for requirements.**

12. **Professional Accountability Points**

    Professional behavior and accountability is an essential part of nursing. To represent the importance the program places on professional role development, on and off campus, nursing courses have a "Professional Accountability" component within the grading criteria.

    1. The program is making the assumption that the student will demonstrate professional accountability and begin a nursing course with 10 Professional Accountability points.
    2. The 10 points are not considered "extra credit" and are included within the total points for any nursing course.
    3. A lack of professional behavior or accountability can result in a point deduction, up to a maximum of 10 points in any component/s of a course.
    4. The following are examples of reasons why points may be deducted (this list is *not* meant to be all inclusive):
       a. Lack of accountability for actions in theory, lab or clinical portions of a course

b. Tardiness or not wearing proper uniform to clinical
c. Turning in assigned work late, incomplete or not at all
d. Disrespectful communication with peers, faculty, or administration within on or off campus environments, including electronic environments
e. Disrespectful communication with patients, peers, hospital staff, faculty within the clinical environment
f. Reckless, inappropriate, or unsafe behavior that could result in patient harm
g. Disregard for university/college, nursing program, or clinical partner policies
h. Disrespectful and inappropriate use of laboratory supplies, equipment or space
i. Inappropriate cell phone use or any other electronic device that has camera and/or text functions

5. Members of the faculty teaching team, and/or progression committee will evaluate each unique situation and determine the amount of any deduction based on situation specifics and severity of breach of professionalism.
6. Dependent upon the severity of the unprofessional accountability or behavior, the student may be required to appear before the dean of nursing and faculty progression committee for further action based upon program policy.
7. A student who receives a professional point deduction will be advised on means by which to improve professionalism and will be held accountable for improved subsequent performance.
8. Repeat instances of professional accountability concerns may be referred to the dean of students/education, dean of nursing and/or faculty progression committee for further action, based upon college and program policy.

GlobeUniversity
& Minnesota School of Business

# BACHELOR OF SCIENCE NURSING PROGRAM RESOURCE MANUAL

## 2016

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# I-A. INTRODUCTION

## Welcome

To: Globe University Nursing Students

From: The Dean of Nursing and Nursing Faculty

Welcome to the Globe University Baccalaureate Nursing Program. The faculty and I look forward to assisting you on your nursing education journey.

This manual serves as a guide to students regarding resources and information for navigation of the nursing program. This manual constitutes the operating policies of the Nursing Program. It will be reviewed and revised annually and made available to all students currently enrolled in the program and upon entry or re-entry.

The most current edition of this manual dictates the policies the program follows each quarter. It is each student's responsibility to have read the manual and follow the policies as stated.

## Program Approval and Accreditation

Globe University/Madison East is _____ by the Wisconsin State Board of Nursing, located at 1400 East Washington Avenue, Room 112, Madison, WI 53703

Globe University/Minnesota School of Business is approved by the Minnesota State Board of Nursing, located at 2829 University Avenue S.E., Minneapolis, MN 55414-33253, 612-617-2270.

Institutional accreditation is provided by the Accrediting Council for Independent Colleges and Schools (ACICS) 750 First Street, NE, Suite 980, Washington, DC, 202-336-6780.

The program is accredited by the Commission on Collegiate Nursing Education (CCNE) 1 DuPont Circle NW, Suite 530, Washington, DC 20036, 202-887-6791.

Upon completion of the program and verification of the Bachelor of Science in Nursing degree, a graduate is eligible to take the National Council of Licensure Examination (NCLEX-RN) to become licensed as a Registered Nurse, provided all State Board of Nursing requirements are met.

# I-B. NURSING PROGRAM MISSION & PHILOSOPHY

## 1. Mission Statement

Globe University Baccalaureate Nursing Program serves the community's need for nurses by preparing graduates as generalists, focusing on leadership in professional practice, and inspiring goals for life-long learning.

## 2. Program Philosophy

The nursing faculty endorses a graduate who demonstrates strong leadership development and capabilities, who clearly understands today's rapidly changing health care environment, and who can quickly adapt to the complex needs of patients, groups, and communities. The faculty values a collaborative partnership between the student, teacher, and learning environment that promotes lifelong learning. The faculty believes successful nursing practice by graduates of the program is facilitated through excellence in the teaching-learning process and through application of practice based on sound evidence from research.

The curriculum is based on a foundation of liberal arts courses and essential nursing knowledge. This acquisition of knowledge supports development of sound clinical judgement and ethical decision-making ability in the graduate nurse, as well as stimulating intellectual curiosity that will support enhancement of the profession.

The nursing program embraces the "*Essentials of Baccalaureate Education for Professional Nursing Practice*" (AACN, 2008) as the foundation for the program goals, outcomes and curricular framework. *The Essentials* "delineate the outcomes expected of graduates of baccalaureate nursing programs. Achievement of these outcomes will enable graduates to practice within complex healthcare systems and assume the roles: provider of care; designer/manager/coordinator of care; and member of a profession" (AACN). The curriculum is designed to include the nine *Essentials* as follows:

- ***Essential I: Liberal Education for Baccalaureate Generalist Nursing Practice***
  - *A solid base in liberal education provides the cornerstone for the practice and education of nurses.*
- ***Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety***
  - *Knowledge and skills in leadership, quality improvement, and patient safety are necessary to provide high quality health care.*
- ***Essential III: Scholarship for Evidence Based Practice***
  - *Professional nursing practice is grounded in the translation of current evidence into one's practice.*
- ***Essential IV: Information Management and Application of Patient Care Technology***
  - *Knowledge and skills in information management and patient care technology are critical in the delivery of quality patient care.*

- ***Essential V: Health Care Policy, Finance, and Regulatory Environments***
  - *Healthcare policies, including financial and regulatory, directly and indirectly influence the nature and functioning of the healthcare system and thereby are important considerations in professional nursing practice.*
- ***Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes***
  - *Communication and collaboration among healthcare professionals are critical to delivering high quality and safe patient care.*
- ***Essential VII: Clinical Prevention and Population Health***
  - *Health promotion and disease prevention at the individual and population level are necessary to improve population health and are important components of baccalaureate generalist nursing practice.*
- ***Essential VIII: Professionalism and Professional Values***
  - *Professionalism and the inherent values of altruism, autonomy, human dignity, integrity, and social justice are fundamental to the discipline of nursing.*
- ***Essential IX: Baccalaureate Generalist Nursing Practice***
  - *The baccalaureate graduate nurse is prepared to practice with patients, including individuals, families, groups, communities, and populations across the lifespan and across the continuum of healthcare environments.*
  - *The baccalaureate graduate understands and respects the variations of care, the increased complexity, and the increased use of healthcare resources inherent in caring for patients.*

Graduates of the nursing program will be expected to integrate the *Essentials* components into their professional role as exemplified by the program's thirteen individual student learning outcomes. Throughout the curriculum students will be exposed to teaching/learning opportunities and evaluation modalities to determine progress towards attainment of core knowledge and competency in practice essential to the generalist role of the baccalaureate-prepared nurse.

## 3. Program Philosophy Related to Nursing Concepts

## Nursing

Nursing is a caring, holistic art that integrates evidence-based knowledge into practice. Nursing, as a profession

- Responds to world and societal changes to promote health, maintain health and if able, restore health
- Respects all life stages and the diversity of those served
- Utilizes critical reasoning and ethical values as a base for decision-making
- Collaborates as a member of an inter-professional healthcare team within local and global environments
- Advocates for individual patients, groups, communities, and the profession of nursing
- Contributes to the body of knowledge through research

## Person

The recipient/s of nursing care is not limited to individuals but also may be the family, groups and/or communities. The nursing program believes that

- individuals define their level of optimum health
- individuals have unique needs depending on their characteristics as an individual and within their definitions of diversity
- individuals, groups and communities may seek or benefit from nursing care through health promotion and disease prevention or during direct illness-related needs
- those that may benefit from nursing care are not limited to a defined geographical space but are interconnected world-wide as a community

## Caring Relationships

Caring occurs within a milieu of respect and serves to develop and support an environment aimed towards positive interactions and goal attainment. Through a caring relationship, the nurse seeks to empower the individual, family, group or community to meet their needs. The caring nurse is an advocate by "watching over, making sure, keeping safe" (Schmidt, 2009). Incorporating caring behaviors into each interaction with the individual, group or community is a basic tenet of the nursing program. As a part of the caring approach to patient care, nursing continuously evaluates delivery systems for optimal improvements through participation in research and implementation of evidenced-based practice.

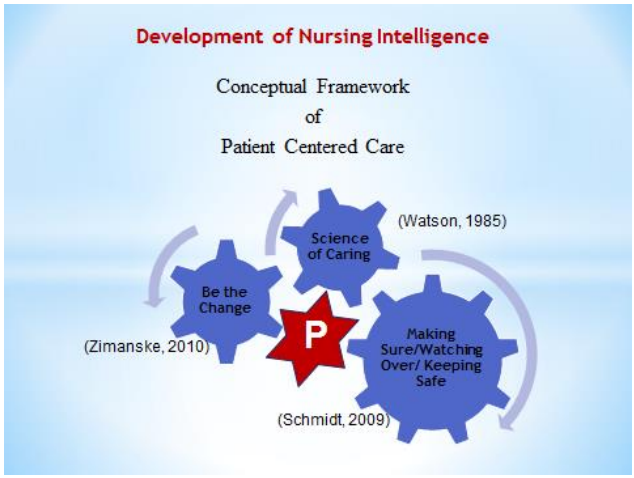
## Health

Health is a dynamic process along a continuum of wellness as defined by the individual, group or community. Health is also striving to obtain a balance and harmony for the body, mind, and spirit that includes the cultural beliefs of the individual, family, group or community. Preparing for death is a component of health.

## Environment

The environment occurs wherever there is an individual, family, group or community that requires nursing care. Environments may be interconnected and may positively or negatively impact health. Within this context, nursing strives to interact and collaborate with the individual to maintain or modify the environment to achieve optimal health. The relationship between the individual and perceived environment is honored and maintained through caring behaviors by the nurse.

## 4. Program Conceptual Framework of Patient Care




- The patient is the center of nursing care.
- Nursing is accountable to ensure the safety of individuals, families and communities as recipients of care.
- Nursing can transform the care experience for individuals, families and communities through thoughtful action based on unique needs.
- Nursing instinct is what stimulates an individual to enter the profession, developing to nursing intelligence through education, experience and personal commitment.

## I-C. PROGRAM GOALS & OUTCOME OBJECTIVES

The goal of the nursing program is to prepare the graduate for entry-level practice as a professional nurse within an academic environment whereby students are:

1. Prepared with the knowledge and skills necessary to function as a professional nurse.
2. Prepared to function within a rapidly changing healthcare environment.
3. Prepared to integrate professional values and ethical decision-making processes into nursing practice.
4. Supported in developing personal goals for life-long professional development.

## I-D. PROGRAM EXPECTED OUTCOMES

The goal of the nursing program is to prepare graduates who are able to meet competency in the 13 Individual Student Learning Outcomes. Each outcome is evaluated within course content as specified in the syllabus and addendum and is identified as a Learner Outcome Assessment (LOA).

1. Integrate nursing knowledge with the humanities, arts and sciences to provide holistic care within the practice of professional nursing.

2. Demonstrate effective critical thinking, communication, assessment, and technical skills in the practice of professional nursing.

3. Collaborate with patients, health care providers and other members of the interdisciplinary team to assess, plan, implement and evaluate patient focused outcomes.

4. Advocate for the patients and consumers of health care within health care delivery systems.

5. Use knowledge of health promotion, risk reduction and disease prevention in providing holistic care to individuals, families, groups and communities.

6. Use knowledge of human diversity, global health care and information technology to promote the health care of individuals across the lifespan.

7. Apply research-based knowledge from nursing and the sciences as a foundation for evidenced based practice in maintaining, restoring and optimizing health.

8. Demonstrate values and ethical behaviors reflective of professional nursing practice.

9. Demonstrate self-awareness in identifying goals for life-long professional development.

10. Incorporate leadership skills into the practice of professional nursing.

11. Demonstrate appropriate written and verbal communication skills.

12. Evaluate the quality of multiple viewpoints, arguments, and evidence and distinguish between fact and opinion.

13. Exhibit social responsibility and examine the diverse cultures and value systems of our global community.

## I-E. PROGRAM REQUIRED COURSE SEQUENCE

Refer to the current College catalog or addendum for current nursing program requirements. The most current program sequence of courses for completion of the BSN degree is available on the Nursing Communication Course on CampusConnect.

**Globe University/MSB Nursing Program by Quarter Plan**

| Quarter/ Year | Course Designator | Course Title | Credits T= lecture L -= Lab C = Clinical | Hours Theory/Lab/Clinical | Pre-requisites Co-requisites |
|---|---|---|---|---|---|
| **Year 1** | | | | | |
| uarter 1 | CM 121<br>NS 135<br>SS 116<br>SS 103<br>**RN 101** | Composition<br>Microbiology<br>Introduction to Psychology<br>Global Citizenship<br>**Essentials of Professional Nursing** | 4<br>4<br>4<br>2<br>**6 (T)**<br>20 cr | **60** | **Admission to the Program** |
| uarter 2 | NS 140<br>SS 210<br>**RN 154**<br>**RN 152** | Anatomy Physiology I<br>Developmental Psychology<br>**Integrative Holistic Care**<br>**Nursing Foundations** | 4<br>4<br>**4(T)**<br>**6 (3T, 2L 1C)**<br>18 cr | **40**<br>**30/40/30** | **Pre: RN 101**<br>**Pre: RN 101** |
| uarter 3 | NS 150<br>MT 166<br>NS 116<br>**RN 156** | Anatomy Physiology II<br>Introduction to Pharmacology<br>College Algebra I<br>**Health Promotion Across the Lifespan** | 4<br>3<br>4<br>**6 (4 T, 1L, 1C)**<br>17 cr | **40/20/30** | **Pre: RN 152, RN 154, SS 210** |
| uarter 4 | MT 165<br>CM 200<br>**RN 201**<br>**RN 202** | Nutrition Supplementation<br>Intercultural Communication<br>**Care of the Adult in Illness I**<br>**Nursing Pharmacology** | 3<br>4<br>**6 (6 T)**<br>**4 (2T, 2 L)**<br>17 cr | **60**<br>**20/40** | **Pre: NS 150; MT 166, RN 156**<br>**Pre: RN 152, MT 166, NS 150** |
| **Year 2** | | | | | |
| uarter 5 | **RN 203**<br>**RN 204**<br>**RN 206** | **Care of the Adult in Illness II**<br>**Nurse as Provider of Care**<br>**Holistic Health Assessment** | **5 (5T)**<br>**8 (3T, 3L, 2C)**<br>**4 (3T, 1L)**<br>17 cr | **50**<br>**30/60/60**<br>**30/20** | **Pre: RN 201**<br>**Pre: RN 201, 202, CM 200**<br>**Pre: RN 201, CM 200** |
| uarter 6 | **RN 302**<br>**RN 303**<br>**RN 304** | **Nurse as Provider and Coordinator of Care**<br>**Family Health in Nursing**<br>**Healthcare Issues Across the Lifespan** | **8 (3T, 3L, 2C)**<br>**3 (3T)**<br>**3 (3T)**<br>14 cr | **30/60/60**<br>**30**<br>**30** | **Pre: RN 203, 204, 206**<br>**Pre: RN 156, 206, SS 210**<br>**Pre: RN 206** |
| uarter 7 | NS 305<br>**RN 305**<br>**RN 404**<br>**RN 307**<br>**RN 306** | Statistics I<br>**Care of Children**<br>**Holistic End of Life Care**<br>**OR**<br>**Care of the Child Bearing Family** | 4<br>**7 ( 5T, 2C)**<br>**4 (3T, 1C)**<br>**7 ( 5T, 2C)**<br>**4 (3T, 1L)** | **50/60**<br>**30/20**<br>**50/60**<br>**30/30** | **Pre: RN 302, 303, 304**<br>**Pre: RN 302, 303,304**<br>**Pre: RN 302, 303, 304** |

| Quarter/ Year | Course Designator | Course Title | Credits T= lecture L -= Lab C = Clinical | Hours Theory/Lab/Clinical | Pre-requisites Co-requisites |
|---|---|---|---|---|---|
| | | **Care of the Critically Ill Patient** | 11-15 cr | | **Pre: RN 302, 303, 304** |
| uarter 8 | CM 320<br><br>**RN 305**<br>**RN 404**<br><br>**RN 307**<br><br>**RN 306** | Writing Research<br><br>**Care of Children**<br>**Holistic End of Life Care**<br>**OR**<br>**Care of the Child Bearing Family**<br>**Care of the Critically Ill Patient** | 4<br><br>**7 ( 5T, 2C)**<br>**4 (3T, 1C)**<br><br>**7 ( 5T, 2C)**<br><br>**4 (3T, 1L)**<br><br>11-15 cr | <br><br>**50/60**<br>**30/20**<br><br>**50/60**<br><br>**30/30** | <br><br>**Pre: RN 302, 303, 304**<br><br>**Pre: RN 302, 303,304**<br><br>**Pre: RN 302, 303, 304**<br><br>**Pre: RN 302, 303, 304** |
| **Year 3** | | | | | |
| uarter 9 | **RN 401**<br>**RN 403** | **Behavioral Health Care**<br>**Nursing Research & Evidence-Based Practice** | **7 ( 5T, 2C)**<br>**3 (3T)**<br>10 cr | **50/60**<br>**30** | **Pre: RN 302, 304, 303**<br>**Pre: RN 302, 304, 303, CM 320, NS 305** |
| uarter 10 | **RN 408**<br><br>Elective | **Community Health Nursing**<br><br>Liberal Arts (if needed) | **7 (4T, 3C)**<br><br>4<br>7-11 cr | **40/90** | **Pre: RN 305, 306, 307, 401, 403, 404** |
| uarter 11 | **RN 405**<br><br>PD260<br>Elective | **Leadership and Management in Nursing**<br>**Professional Development**<br>Liberal Arts (if needed) | **7 (5T, 2C)**<br><br>2<br>4<br>7-13 cr | **50/60** | **Pre: RN 305, 306, 307, 401, 403, 404** |
| uarter 12 | **RN 409**<br><br>**RN 413** | **Nursing Within a Global Community**<br>**Nursing Internship / Professional Role Development** | **3 (3T)**<br><br>**7 (3T, 4C)**<br><br>10 cr | **30**<br><br>**30/120** | **Pre: RN 405, 408**<br><br>**Pre: RN 405, 408** |
| | | **TOTAL CREDITS** | **180 credits** | **830/260/660**<br>**1790 RN Hours** | |

Baccalaureate Degree Requirements:

RN 119 credits
MT 6 credits } Core Credits = 125
LA 54 credits minimum for Degree ( See below)
PD 2 credit
181 total BSN credits

Liberal Arts:
CM 121, 200, 320 12 credits
SS 103, 116, 210 10 credits
NS 116, 135, 140, 150, 305 20 credits
HU need 6 credits (Choice)
Electives to meet degree requirements 4 credits

Upper Division 74 RN credits 8 Liberal Arts credits 82 credits 45.5% Upper Division (need at least 30% Upper Division courses for BS Degree)

# SECTION II:

# RESOURCES

## II-A. STUDENT NURSE ASSOCIATION

### 1. OVERVIEW

In 2006, the first students admitted to the nursing program initiated a student nurse organization on campus, the Globe University/ Minnesota School of Business Nursing Organization (MSBNO). In 2010, the student body took on the initiative of advancing the organization to become a state chapter of the National Student Nurse Association. The Nursing Program is a dues paying, supporting member of the National Student Nurse Association.

**Purpose:**
The Association has a three-fold purpose supporting professional development at the baccalaureate level of education:

- *Scholarship*
- *Practice*
- *Service*

**Mission Statement:**

- *The mission of the Globe University Student Nurse Association is to create a united baccalaureate nursing community.*
- *We are dedicated to the delivery of scholarship, service, and social opportunities which impact holistic nursing on a local, national, and global platform.*
- *Additionally, we provide mentorship and ongoing support to students thereby enriching their educational experience.*
- *Our commitment is to empower our organization through compassion, advocacy, and leadership allowing us to champion the highest quality health care.*

*(revised March, 2011)*

**Financial Policies:**

- Funds gained by the Association through fund-raising projects are held in a checking account in the name of the Student Nurse Association. The account is jointly held by the Dean of Nursing and current Treasurer. Provisions are being made for auditing of the account on an annual basis.

## 2. STUDENT NURSE ASSOCIATION BYLAWS

GLOBE UNIVERSITY
MINNESOTA SCHOOL OF BUSINESS
SUCCESSFUL FUTURES START HERE!

ARTICLE I - NAME OF ORGANIZATION
Section 1. The name of this organization shall be the Globe University Student Nurses Association, herein referred to as Globe University SNA.

ARTICLE II – PURPOSE AND FUNCTION
Section 1. Purpose

A. To assume responsibility for contributing to nursing education in order to provide for the highest quality of health care.
B. To provide programs representative of fundamental interests and concerns to nursing students.
C. To aid in the development of the whole person, including his/her professional role, his/her responsibility for health care of people in all walks of life.

Section 2. Function

A. To have direct input into standards of nursing education and influence the education process.
B. To influence health care, nursing education and practice through legislative activities as appropriate.
C. To promote and encourage participation in community affairs and activities towards health care and the resolution of related social issues.
D. To represent nursing students to the consumer, to institutions, and other organizations.
E. To promote and encourage students' participation in interdisciplinary activities.
F. To promote and encourage recruitment efforts, participation in student activities, and educational opportunities regardless of a person's race, color, creed, national origin, ethnicity, age, gender, marital status, lifestyle, disability or economic status.
G. To promote and encourage collaborative relationships with nursing and health related organizations.

ARTICLE III - MEMBERS
Section 1. School Constituent

A. School constituent membership is composed of active or associate members who are members of the NSNA and the state association when one exists.
B. Globe University SNA shall be composed of at least 10 members from GU/MSB or the total school enrollment if less than 10. There shall be only one chapter on this school campus.
C. For yearly recognition as a constituent, an officer of the Globe University SNA shall submit annually the Official Application for NSNA Constituency Status which shall include the following areas of conformity: purpose and functions, membership, dues, and representation.
D. A constituent association that fails to comply with the bylaws and policies of NSNA shall have its status as a constituent revoked by a 2/3 vote of the Board of Directors, provided that written notice of the proposed revocation has been given at least two months prior to the vote and the constituent association is given an opportunity to be heard.
E. Globe University SNA is an entity separate and apart from NSNA and its administration of activities, with NSNA and the Wisconsin Student Nurse Association (MSNA) exercising no supervision or control over these immediate daily and regular activities. NSNA and MSNA have no liability for any loss, damages, or

injuries sustained by third parties as a result of the negligence or acts of Globe University SNA or the members thereof. In the event any legal proceedings are brought against NSNA and WSNA, Globe University SNA will indemnify and hold harmless the NSNA and MSNA from any liability.

Section 2. Categories of Constituent Membership
Members of the constituent associations shall be:

A. Active members:
1. Students enrolled in state approved programs leading to licensure as a registered nurse.
2. Registered nurses enrolled in programs leading a baccalaureate degree with a major in nursing.
3. Active members shall have all the privileges of membership.

B. Associate members:
1. Pre-nursing students, including registered nurses, enrolled in college or university programs designed as preparation for entrance into a program leading to an associate degree, diploma or baccalaureate degree in nursing.
2. Associate members shall have all of the privileges of membership except the right to hold office as president or vice president at state and national levels.

C. Individual members:
Individual membership shall be open at the national level to any eligible student when membership in a constituent association is not available. Individual members shall have the privileges of membership as prescribed in NSNA bylaws.

D. Active and associate membership shall be renewable annually.

Section 3.
Active and associate NSNA membership may be extended six months beyond graduation from a student's program in nursing, providing membership was renewed while the student was enrolled in a nursing program.

ARTICLE IV - DUES
Section 1.

A. The Annual NSNA dues for active and associate members shall be $30 per member, which includes state dues, plus $10 school dues, payable for the appropriate dues year. The dues year for membership shall be a period of 12 consecutive months.

B. The annual NSNA dues for active and associate members joining for two years shall be $50 per member, which includes state dues plus $10 school dues, payable for the appropriate dues years. The dues years for these members shall be a period of 24 consecutive months.

D. National and state dues shall be payable directly to NSNA. NSNA shall remit to each state constituent the dues received on behalf of the constituent. NSNA shall not collect nor remit school chapter dues.

E. Any member who fails to pay current dues shall forfeit all privileges of membership (NSNA does not collect school chapter dues; this is the responsibility of the school chapter).

ARTICLE V – BOARD OF DIRECTORS
Section 1. Composition.

A. The Board of Directors will consist of four officers – President, Vice President, Secretary, and Treasurer – and Board Members-At-Large.
B. Board of Directors members must have an active membership in NSNA.

Section 2. Responsibilities

A. The Board of Directors shall be responsible for:
1. Transacting business of the association between membership meetings and shall report such

transactions at the next regularly scheduled membership meeting.
2. Filling vacancies in any officer position by majority vote of Board of Directors, except the office of President.
3. Reviewing monetary disbursements, acquisitions and fund raising activities and shall be responsible for procuring persons for audit of all accounts on an annual basis.
4. Presenting the Globe University SNA Annual Report at the GU/MSB Nursing Forum each year. The Annual Report will include a review of the activities and budget of the last year as well as goals and plans for the coming year.
5. Annually submitting the Official Application for NSNA Constituency Status to maintain school constituent membership in the NSNA and MSNA (see III.1.c. above).

Section 3. Quorum. A quorum for the board meetings shall be 51% or more of the board members and a faculty advisor.

Section 4. Duties of the Board of Directors shall consist of:

A. President

1. Shall preside at all meetings of this association, appoint special committee as needed, perform all other duties pertaining to the office and represent this association in all matters to the local state nurses association, the local league for nursing, state nursing student association, National Student Nurses' Association, and other professional and student organizations.
2. Shall serve as chairperson of the Board of Directors
3. Provide meeting agenda and secure meeting location.
4. Recruit and retain members.

B. Vice President

1. Shall assume responsibility of the office of President in the event of the vacancy occurring in the office until the next regular election.
2. Shall preside at meetings in the absence of the President.
3. Shall assist the President as delegated and act as advisor to the President.
4. Recruit and retain members.

C. Secretary

1. Shall record and distribute the minutes of all meetings of this association as directed by the President.
2. Shall keep on file as a permanent record all reports, papers and documents submitted to the Secretary.
3. Refer to duly appointed committees the necessary records for the completion of business.
4. Forward minutes to the state nursing student association board as well as the names and addresses of all officers and committee chairpersons after their election or appointment.
5. Deliver to the newly elected Secretary all association papers.
6. Record and report attendance.
7. Recruit and retain members.

D. Treasurer

1. Submit financial reports to the membership as directed by President.
2. Prepare financial reports submitted at the scheduled Board of Directors Meeting.
3. Keep a permanent record of all dues received from members and any other income and expenses.
4. Remit payment for approved debits according to the following:

a) Disbursement of Funds

*1. Requests for disbursement of funds shall be made in writing to the Board of*

*Directors.*
*2. Upon approval the treasurer will issue checks for those requests approved.*
*3. No funds will be disbursed without prior approval.*

5. Recruit and retain members.

E. Board Member-At-Large

1. One student representative from each student cohort will be elected to attend board meetings and represent the members of her/his student cohort.
2. At quarterly nursing faculty meetings, represent the members of her/his student cohort and also the Globe University SNA as a whole.
3. Recruit and retain members.

Section 5. Absences

A. Members of the Board of Directors who have missed more than two regularly scheduled meetings of any current term year without prior notification to the Board of Directors and who offer no valid reason for such absences may be removed from office by a plurality vote of the current membership present at the next scheduled meeting. The officer in question will be notified in advance of the meeting.

B. An officer may also be removed from office by a plurality vote of the members of the Board of Directors present at a meeting called for that purpose if that officer is deemed negligent in the functions of that office as stated in these bylaws. (Prior notification of two weeks shall be given to the individual in question and a special Board of Directors meeting shall be held to review the circumstances.)

ARTICLE VI - ELECTIONS

Section 1. Election of Board of Directors

A. Elections shall be held at the annually per current policies and procedures.

ARTICLE VII - MEETINGS

Section 1. Membership Meetings

A. Meeting dates, times and locations shall be set by a plurality vote of the Board of Directors.

B. The President or faculty advisor shall have the authority to convene a special meeting as such time as is deemed necessary and shall notify the general membership of such meeting, location, and time.

ARTICLE VIII - COMMITTEES

Section 1. Appointments

A. Committee chair appointments shall be made by the Board of Directors and shall be deemed standing committees unless otherwise stated at time of appointment.

B. Committee members shall be appointed by the committee chairperson or selected by the Board of Directors from a group of volunteers.

Section 2. Responsibility

A. All committees shall be responsible to the Board of Directors for reporting committee activities on a regular basis and shall, upon direction of the Board of Directors, report same to the general membership.

ARTICLE IX - DELEGATES

Section 1. Purpose and Function

A. To serve as spokesperson for this association at the annual state and national conventions.

B. Present to the state and national organizations all proposed resolutions or amendments to bylaws or policies proposed by this association.

C. Keep informed as to all current and proposed resolutions at the state and national levels and report

information to this association's membership at regularly scheduled membership meetings.
D. Make available to members updates, explanations, and copies of current and proposed state and national resolutions.

Section 2. Qualification and Appointment

A. Any member maintaining a grade level of C or above, who is active in Globe University SNA projects and is nominated by current membership at a regularly scheduled meeting is eligible to hold the position of delegate.

B. Appointment shall be for one (1) year and shall be made by nomination per current policies and procedures.

Section 3. Delegate Representation

A. School constituents:

1. Globe University SNA, when recognized as an official NSNA constituent, shall be entitled to one voting delegate and alternate at the NSNA House of Delegates, and in addition, shall be entitled to one voting delegate and alternate for every 50 members.

2. The Globe University SNA delegate(s) and alternate shall be a member(s) in good standing in the chapter and shall be selected and/or elected by members of the school chapter at a proper meeting according to chapter bylaws. The school association may designate an alternate delegate for each delegate by one of the following two mechanisms:

a) Selection and/or election by members of the school chapter according to chapter bylaws; or

b) Written authorization to the State Board of Directors requesting them to appoint a member of the State Board to act as a state-appointed alternate for their school chapter.

*1. School chapters shall approve the appointment.*

*2. The State Board of Directors shall verify that any state appointed alternate is a member in good standing of the NSNA and the state association.*

*3. A school chapter must have a selected and/or elected delegate present at the NSNA Convention in order to have a state-appointed alternate seated in the House of Delegates.*

*4. All alternates, whether school selected or state-appointed, shall have the same privileges as an elected delegate when seated in the House.*

3. The school association shall be entitled to delegates according to the number of members in good standing in NSNA. Delegates shall be computed on the basis of the number of members in each constituent as evidenced by the annual dues received by NSNA on a date eight weeks prior to the annual meeting.

ARTICLE X - AMENDMENTS

Amendments to the Bylaws may be made with a 2/3 vote of those present and voting at a membership meeting provided that notice of proposed amendments has been sent to members at least two weeks prior to the meeting. Only proper amendments submitted in writing and carrying the proponent's signature will be considered.

## 3. STUDENT PARTICIPATION IN PROGRAM GOVERNANCE POLICY

**Policy for Student Representation to Faculty Meetings and Program Governance**
*October, 2007; Amended 2012*

**Purpose:**

The mission and goals of the nursing program support development of the student "as a generalist, focusing on leadership in professional practice, and inspiring goals for life-long learning" (Program Mission Statement, 2012). The faculty also values a collaborative partnership between the student, teacher, and learning environment that promotes lifelong learning and prepares the student to integrate professional values and ethical decision-making processes into nursing practice (Program Goals and Objectives, 2012). Representation from the student body to faculty meetings will assist the students to:

1. Participate in program governance and policy making to improve program quality.
2. Ensure that the student voice is heard regarding items of concern.
3. Experience the application of decision-making processes within a community.
4. Develop leadership and advocacy skills.
5. Demonstrate values and ethical behaviors reflective of professional nursing practice.
6. Incorporate leadership skills into the practice of professional nursing.

**Guidelines:**

a. Representation is required from all cohorts within the student body.
b. Representatives are to be elected by the student body as a component of the Globe University Student Nurse Association (GUSNA). Elections will be held each fall quarter.
c. Representatives may be primary and alternate in order to maintain a presence at faculty meetings.

**Position Requirements:**

1. Representatives must be able to attend quarterly faculty meetings. Dates and times will be determined at the beginning of each quarter. Representatives will be excused from meetings when topics are of a confidential nature not applicable to open discussion with the entire student body.
2. Representatives will function as a liaison for the entire student body and therefore must have good communication skills and the ability to solicit and impart information in an objective and factual manner.
3. Representatives will submit agenda items to the nursing department one week ahead of meeting time for inclusion into the meeting agenda.
4. Representatives will participate in meaningful discussion while in attendance at meetings and maintain professional behaviors. As appropriate, the representatives will bring suggestion for possible solution to agenda items, introduced from the student body, as discussion points.
5. Representatives will develop a means to impart the results of discussions and decision items at faculty meetings to the student body in a timely and professional manner.
6. Representatives and alternates will serve for one year and then be subject to re-election as determined by the entire student body.

**Policy and Position Review:**

Review and revision of policy and student representation position will be discussed at an open faculty meeting annually, prior to re-election of student representatives. SNA representatives and current student representatives will be included in the discussion.

**Process for Candidate Election:**

Students will use the attached Student Representative Candidate Application.

All entries will be compiled and presented to the class to be read and voted upon by ballet vote. The student receiving the most votes will be the liaison/representative. The student receiving the second highest number of votes will be the alternate if the representative has a conflict and cannot attend a meeting.

The results will be announced in RN 101. The students elected will then be contacted by the nursing department (Nursing Project Coordinator or Dean of Nursing) and given the schedule of faculty meetings and welcomed to the process.

## 4. STUDENT REPRESENTATIVE CANDIDATE APPLICATION

**CANDIDATE APPLICATION:**
**Student Representative to Faculty Meetings**

Student Liaison /representation to faculty meetings is an elected position, determined through class vote. Interested students are invited to complete the following items, articulating rationale for choosing to be a liaison, and identifying individual qualifications for the position.
Please complete the following three questions/statements in a word-processed document and return to Kendra Saal (ksaal@msbcollege.edu) no later than _____. Voting will take place, in class, on _____.

1. Why do you wish to be the liaison /representative? Articulate your reasons for desiring to be the class representative to faculty meetings.

2. Identify and explain what strengths and attributes you possess that would assist you in fulfilling the responsibilities of representing the student body at faculty meetings.

3. Are you willing to assume responsibility for communicating with the class, thereby ensuring that students have opportunity to identify topics for discussion at faculty meetings? How will you do this?

# II-B. SIGMA THETA TAU INTERNATIONAL, THE HONOR SOCIETY OF NURSING

## 1. OVERVIEW

On November 3, 2012, the Globe University/Minnesota School of Business (GU/MSB) nursing program became an official member of the Sigma Theta Tau International, the Honor Society of Nursing by joining the Chi-At-Large chapter.

Chi-At-Large includes four other member programs: *Bethel University, Gustavus Adolphus College, St. Olaf College, and St. Catherine's University.*

**For more information:**

- Sigma Theta Tau International website: www.nursingsociety.org
- Chi-At-Large website: www.chi-at-large.org

## 2. HONOR SOCIETY MEMBERSHIP CRITERIA

### a. Criteria for Students

Students must have a minimum 3.0 GPA to be considered, per STTI guidelines. The remaining criteria are as follows:

***Excerpt from the Chi-At-Large Chapter Bylaws:***

Section 2. ualifications for Regular Membership

a. Sigma Theta Tau International does not discriminate. Candidates are qualified for membership so long as eligibility requirements are met.
b. Student candidates shall have demonstrated superior academic achievement, academic integrity, and professional leadership potential.
c. Regular Member
   1) **Students in Basic Program**
      a) Definition – Basic program is defined as a baccalaureate or equivalent nursing degree program which leads to the first professional nursing degree.
      b) Academic Achievement – Students in basic programs shall be eligible for membership if they have achieved excellence according to the standards approved by the Society.
      c) Rank in class – Basic students who are elected shall rank not lower than the highest 35 percent of their class in scholarship.
      d) Curriculum – Students shall have completed at least one-half of the required nursing curriculum.
      e) Exceptions – Exceptions may be made at the discretion of the chapter's governance committee following the guidelines adopted by the International Board of Directors.

### Criteria for alumni post-graduation

Students who were not invited to join the Honor Society of Nursing as a student can submit an application for membership after becoming a licensed RN. The criteria are as follows:

***Excerpt from Chi-At-Large Chapter Bylaws:***

Section 2. ualifications for Regular Membership

c. Regular Member

**3) Nurse Leader**

A nurse leader, who is a registered nurse, legally recognized to practice in his/her country with a minimum of a baccalaureate degree or the equivalent in any field, and who has demonstrated achievement in nursing, shall be eligible for membership.

## 3. PROCESS OF EVALUATION FOR HONOR SOCIETY MEMBERSHIP INVITATION

- GU/MSB students are evaluated once for Honor Society membership.
  - All students who have successfully completed 50% of the program will be assessed as a group.
  - Evaluation occurs twice a year, in early January and in early July. This is due to the fact that we have two admission dates and groups of students reach the 50% point twice a year.
    - *A student must accept or decline the invitation within six (6) weeks of the invitation. Taking no action is the same as declining.*
    - *A student who declines the invitation will not receive another opportunity to join under the Student Criteria.*
    - *Induction for both the January and July groups will occur at Chi-At-Large's annual Induction ceremony, which is held in November.*
  - Once a student has been evaluated under student criteria, they cannot be evaluated again, even if GPA changes at a later point in the program.
    - *Note: After graduation, alumni may apply under Nurse Leader criteria, if they wish.*

# II-C. NURSING STAFF AND FACULTY

## 1. NURSING PROGRAM ADMINISTRATION

| Title | Name | Email | Phone # |
|---|---|---|---|
| Dean of Nursing | Kendra Saal, MSN, RN | ksaal@globeuniversity.edu | 612.455.4781 |
| Nursing Department Chair | Susan Olson, MSN, RN | susanolson@globeuniversity.edu | 608.216.9465 |
| Director of Clinical Affiliations and Processes | Heather Hakanson, BA | hhakanson@globeuniversity.edu | 612.436.7543 |

## 2. NURSING LEARNING CENTER/LABORATORY

| Title | Name | Email | Phone # |
|---|---|---|---|
| Director of Simulation and Lab Educaton | | | |

## 3. NURSING FACULTY

Full-time Faculty

Adjunct Faculty*

*Refer to course syllabi and addendum each quarter for current listing of adjunct faculty and contact information.

# II-D. TUTORING

Bachelor of Science in Nursing: Nursing Tutor Role

The program has a designated nursing expert who is available to students for tutoring related to the program curriculum content. This includes theory, lab and clinical components. The nursing tutor is introduced to students in RN 101 Essentials of Professional Nursing Practice within the first quarter of the program. At that time the role, contact information, and hours for tutoring are shared with students.

The nursing tutor contact information is listed in the Program Resource Manual and given in RN 101 as part of class content.

1. Students are encouraged to contact the tutor related to individual needs at any time throughout the program.
2. Tutoring hours are arranged by individual appointment and/or through open lab hours posted each quarter outside of the lab.
3. Students are expected to bring assignments and prepared questions when meeting with the Tutor to utilize the time to the best advantage for learning needs.
4. Faculty may refer students to the tutor for specifically identified needs in class, lab or clinical.
    a. If a student is referred for tutoring, it is the student's responsibility to contact the Tutor and make an appointment.
    b. The Tutor will develop a plan with the student, based on the individual learning needs.
    c. As needed, the Tutor will inform the referring faculty when the student has met/not met the learning objectives, based on the student learning need identified.
5. Progression meetings, related to failure of an RN course, will result in a referral to the Tutor with mandatory criteria to fulfill related to student need.

Examples of tutoring opportunities:

1. Critique of written paperwork
2. Dosage calculation and critical reasoning support
3. Clinical competency remediation
4. Simulation preparation
5. Review of theoretical components of curriculum
6. Review and practice of test-taking strategies
7. Coaching of skills in preparation for skills testing
8. Discussion and development of organization skills and time management strategies

Students are highly encouraged to utilize the tutor at any given time for learning support.

# II-E. ATI

**ATI Procedures**

ATI Student Learning Support and Program Policy for Implementation

Assessment Technologies (ATI) is the system the nursing program uses to assist students in preparing for the NCLEX-RN exam while in the program and upon graduation. In addition, ATI provides students with added activities and resources to develop clinical reasoning.

The system is comprised of ATI's Comprehensive Assessment and Review Program (CARP) including multiple learning modalities which are used throughout the program.

1. Content Mastery Series® provides assessment data regarding mastery of concepts in specific areas linked to the NCLEX test plan. Subjects addressed include the following:
    - Fundamentals
    - Pharmacology
    - Adult Medical Surgical
    - Focused Adult Medical Surgical
    - Maternal-Newborn
    - Nursing Care of Children
    - Mental Health
    - Community Health
    - Nutrition
    - Leadership and Management

Each series includes multiple proctored assessments and online practice tests, as well as review materials in print and online formats. Books, online videos and Internet resources are utilized to fit the many types of learning styles. Each student receives an in-depth analysis followed by focused remediation which ties directly back to NCLEX.

Courses that include ATI content and exams are listed in the following table and in the Nursing Program "Blueprint".

| Course | ATI Content | Student Evaluation<br>* See grading criteria below number 5. |
|---|---|---|
| RN101 | Critical Thinking | Critical Thinking Entrance Proctored Exam |
| RN152 | Begin Fundamentals Content | Skills Modules<br>HIPPA Skill Module<br>Fundamentals Practice Exams |
| RN201 | Begin Adult Medical-Surgical Content<br>Nutrition Content | Medical-Surgical Practice Exams |
| RN202 | Nursing Pharmacology Content<br>Fundamentals Content | Pharmacology Practice Exams<br>Skills Modules<br>Pharmacology Proctored Exam |
| RN203 | Fundamentals Content<br>Nutrition Content<br>Nursing Pharmacology Content<br>Adult Medical-Surgical Content | Medical-Surgical Practice Exams<br>Medical-Surgical Proctored Exam |

| | | |
|---|---|---|
| RN204 | Fundamentals Content<br>Nutrition Content<br>Nursing Pharmacology Content<br>Adult Medical-Surgical Content | Fundamentals Practice Exams<br>Nutrition Practice Exams<br>Nutrition Proctored Exam |
| RN206 | Assessment Content | Skills Modules: Health Assessment |
| RN302 | Fundamentals Content<br>Nursing Pharmacology Content<br>Adult Medical-Surgical Content | Fundamentals Practice Exams<br>Fundamentals Proctored Exam |
| RN305 | Nursing Care of Children Content | Pediatric Practice Exams<br>Pediatric Proctored Exam |
| RN306 | Maternal–Newborn Content | Maternal–Newborn Practice Exams<br>Maternal–Newborn Proctored Exam |
| RN307 | Care of the Critically Ill Patient | Drug/dosage Calculations<br>Skills Modules/Exam |
| RN401 | Mental Health Content | Mental Health Practice Exams<br>Mental Health Proctored Exam |
| RN405 | Leadership and Management Content<br>STTI Nurse Manager Certificate | Leadership and Management Practice Exam<br>Leadership and Management Proctored Exam<br>STTI Nurse Manager Certificate Modules |
| RN408 | Community Health Content | Community Health Practice Exams<br>Community Health Proctored Exam |
| RN413 | Critical Thinking Content | All Practice Exams<br>Critical Thinking Exit Proctored Exam<br>Proctored Comprehensive Predictor Exam |
| Graduation | | Virtual ATI Review with mentor based on Comprehensive Predictor Exam Results |

2. Complete information on ATI resources is given to the student in the first quarter of the program in the RN 101 course and through the Nursing Communication Class in CampusConnect
    - Access codes to practice exams are posted on CampusConnect in the Nursing Communication Class under Unit Content and are accessible to all students once admitted to the program.
        - All students will be issued a CDN access code, based on graduation month and year, in RN 101.
        - When creating a student ATI account on-line, click on “Products” tab and enter the CDN access code. Access to the learning support system will be opened for use.
        - If a graduation date changes, a new CDN code will be assigned.
    - Practice exams may be taken multiple times.
    - Students are introduced to NurseLogic, NurseLogic 2, ATI Nursing Getting Started, and Learning System RN in RN 101.

- Contact the Nursing Project Coordinator if unable to access the learning system or practice exams.

3. In RN 152, students are introduced to Skills Modules. Skills Modules is a tutorial-based learning system that provides information regarding accepted practice, evidence-based research, practice challenges, frequently asked questions, documentation guide, and progress report for 27 common nursing skills. HIPPA content is mandatory for this class.

4. Proctored exams (on-line) on specific content areas are given periodically throughout the program and are included as a required component of a course.

5. Periodically throughout the program, components of ATI assessment/evaluation are incorporated into a course grade.
   - Practice exams are given points in specific courses per course syllabus and addendum
   - Proctored exams are included in course evaluation for 12 points and given a point award based on the score a student achieved on the exam:
     - ***Level 3 = 12 points***
     - ***Level 2 = 9 points***
     - ***Level 1 = 6 points***
     - ***Below Level 1 = 3 points***
   - Students are not allowed to retest a proctored exam for an improved score unless specified in the course syllabus and addendum

6. In RN 405, students will obtain a Sigma Theta Tau International (STTI) Nurse Manager Certificate. This certificate is offered through a focused online educational program designed to help students acquire the nursing leadership skills needed to become successful nursing managers. The evidence-based curriculum, which consists of teaching materials, self-assessment exercises and case studies, is created and peer-reviewed by experienced clinical and academic nurses. Course work includes team building, mentoring, conflict resolution, budgeting, data analysis, quality processes and more.

7. In preparation for RN 413, students are required to complete assigned Skills Modules during the three months prior. Points will be awarded in the RN 413 course.

8. The Comprehensive Predictor® Assessment is a proctored exam comprised of NCLEX-style questions to help determine student's preparedness for the NCLEX-RN exam and is administered in RN413. Because this test does not use the Level 1-3 system, points are awarded based on percentage earned. See RN 413 addendum for point totals.

9. The student is to review all reports from practice and proctored exams as determined by course requirements and faculty recommendation to support learning and develop competency.

10. Virtual ATI review is initiated upon graduation and is included in the quarterly ATI fee assessed and included in student tuition and books fees.

11. Virtual ATI and NCLEX preparation information is given to students in RN 413 as a means to support success in NCLEX.

12. ATI testing is not optional but a requirement of individual course and program outcomes.
    - Students are expected to fulfill ATI learning requirements within each course.
    - Total program ATI fees will be assessed each quarter and are dependent on current costs of the learning system.
    - The total cost is divided evenly over the 12 quarters of the program.
    - ATI fees will be seen on a student fee statement attached to one RN course each quarter
    - If a student repeats a course in which an ATI fee is assessed the student will pay the fee again unless otherwise indicated.

## II-F. NURSING FORUM

The MSB Annual Nursing Program Forum is held annually; typically during Nurses Week in May as a component of celebrating the nursing profession.

The purpose of the forum is to inform students of program accomplishments from the past year and goals for the upcoming year, and discuss current and emerging issues in the profession.

- Attention is given to scholarly presentations by leaders in nursing, relevant to current nursing and healthcare issues.
- The Annual Program Survey is administered.
    - Survey data is analyzed at the summer faculty retreat and used to advance change within the program that supports student attainment of outcomes
    - Student responses are shared with SNA (anonymously) to support student involvement in program governance
    - Survey data analysis supports review and potential revision of annual program objectives for the ensuing year

Attendance is mandatory for the Forum; classes are adjusted that day to accommodate attendance.

Professional Accountability points will be deducted for absent from nursing forum. IN addition, if the form takes place during class time, you will be marked absent for that class period.

The Forum Planning Committee is comprised of:

- The Dean of Nursing
- Nursing Faculty Volunteers
- SNA Officers

Planning meetings will occur in the three months preceding the event.

The hours of the Forum are typically 9 am to 3 pm.

# SECTION III:

# POLICIES & GUIDELINES

## III-A. REGISTRATION GUIDELINES

When preparing to register for the next quarter in the program, please note the following programmatic and college procedures:

1. All nursing students register with their Nursing Program Advisor for RN courses and general education courses as required.

    a. **Prior to or by WEEK 4**: The Dean of Nursing will communicate the next quarter schedule to students, via MSB e-mail and the Nursing Communication Class in Campus Connect, by week 4 of the quarter and will include the following information:
        i. Courses offered
        ii. Sections of courses as applicable, including day and time
        iii. Courses with multiple components:
            1. theory and lab days and times are combined into a section; note the times and days
            2. clinical registration occurs through the nursing department and is not included in Portal registration*****
                a. Students will receive information on clinical sites, days and times from the Nursing Project Coordinator
                b. Explicit directions will be included in the above information
        iv. Information specific to each course that the student will need to know for planning purposes

*******Clinical registration is dependent upon receipt of acknowledgement by the program that a site/learning opportunity has been granted to the program. In some instances this information is given to the program in a delayed fashion and may cause a delay in the student body receiving registration information. The program makes every effort to impart information about registration to students as early as possible to assist in planning.*

    b. **WEEK 4:** During week 4, students are to connect with their nursing faculty advisor for issues, needs and questions regarding the schedule.
    c. For courses that have multiple sections, students register on a first come-first serve basis until a section is full.
        i. If a section is full, the DOS will register students in an open section
        ii. RN courses do not have a wait list
    d. **WEEK 6**: The Dean of Students will officially register students into classes via Campus View

2. Students are responsible for ensuring that any holds on their student records are cleared prior to the beginning of registration. If a hold is in place the student will not be able to register and may not have first choice of sections in a class.

3. Students should follow the program plan in this guide when planning registration, the current college catalog, and the quarter schedule when published.

# III-B. PROGRAM PROGRESSION & GRADUATION REQUIREMENTS

1. **Background Study**

Wisconsin law requires health care facilities, licensed by the Wisconsin Department of Health, have a background study conducted by the state for individuals who provide direct contact services to patients and residents in their facilities and programs. These studies are required each year. Students will complete the study during initial program orientation and annually in January or July through graduation. The Nursing Project Coordinator will facilitate the study and maintain the results in the student nursing file.

The nursing program is required to provide documentation to all clinical partners that students, participating in a clinical course within their facility, are cleared to provide care without restrictions.

- An individual who is disqualified as a result of the study, and whose disqualification is not set aside by the Commissioner of Health, will not be permitted to participate in any clinical activities in a Wisconsin licensed health care facility.
- A student who refuses a background study, or is disqualified as a result of the study, and whose disqualification is not set aside by the Commissioner of Health, will not be able to enroll in, or complete a course that has clinical experience as a component for successful completion. The student will be unable to successfully complete the requirements of the course/s and the program and may be exited from the program.

Students who are disqualified, or fail to participate in the background study process, will be counseled to 1) drop registration prior to the start of the quarter or 2) withdraw from a course requiring clinical experience, before the date on the college calendar indicating the last day to drop or withdraw. If it is past this date, or a student chooses not to withdraw, the student will receive a grade of “F” for the course. If the student refuses to participate in the background study, the clinical facility will refuse to accept the student.

2. **HIPPA Requirement**

Students are required to complete and sign a Nursing Program Confidentiality Form prior to their first clinical experience. Students should retain a copy. The original will be placed in the nursing program student file.

Students are required to complete HIPPA education in RN 152 Nursing Foundations as preparation for clinical. Information is included in the course syllabus and addendum.

Prior to beginning any clinical experience in the nursing program, students may be required to complete facility specific Health Insurance Portability and Accountability Act (HIPPA) training according to policy/procedure of the facility.

3. In order to progress within the nursing curriculum and qualify for graduation with a Bachelor of Science in Nursing, the student must meet the following requirements:
   a. Obtain a minimum GPA of 2.0 on all course work each quarter
   b. Earn grades of "C" or greater in all liberal arts, medical technology and nursing courses. A grade less than "C" constitutes a failure and will be reflected on the college transcript as a "D*" or "F", depending on grade earned.

4. **Nursing program students will not be allowed to continue in the nursing program if they have failed or withdrawn from:**
   **a. the same nursing course more than once.**
   **b. two different RN courses over more than one quarter (including a course previously failed and repeated with a passing grade).**

   Refer to "Conditions for Exit" from the Nursing Program in this manual for complete information.

5. The deadline for completing all nursing course requirements is the last day of the quarter unless specified differently in course addendum or quarter calendars.

6. Incompletes must be completed by the last day of late registration of the subsequent quarter per college policy. An incomplete grade not completed by the deadline will be changed to an "F" and will be included in the cumulative grade point average.

7. Completion of clinical hours may not be extended beyond the date given at the beginning of each quarter and per course addendum. Incompletes will not be given due to absence days in a clinical rotation.

8. Competency test-out requirements must be completed within program specifications and by the deadline given in course addendum and quarter calendars.

9. Students must adhere to the Standards of Conduct contained in the Nursing Program Resource Manual and College Conduct Policy as stated in the College Catalog and Student Handbook/Planner.

10. Student Disability Statement – The Nursing Program follows the Student Disability Policy as stated in the College Catalog.

11. All components of a nursing course are required to be completed in order to determine a final course grade. **Not completing a course requirement will result in automatic failure of the course (refer to individual course syllabi and addenda for requirements.)**

12. **Professional Accountability Points**

Professional behavior and accountability is an essential part of nursing. To represent the importance the program places on professional role development, on and off campus, nursing courses have a “Professional Accountability” component within the grading criteria.

1. The program is making the assumption that the student will demonstrate professional accountability and begin a nursing course with 10 Professional Accountability points.
2. The 10 points are not considered “extra credit” and are included within the total points for any nursing course.
3. A lack of professional behavior or accountability can result in a point deduction, up to a maximum of 10 points in any component/s of a course.
4. The following are <u>examples</u> of reasons why points may be deducted (this list is *not* meant to be all inclusive):
    a. Lack of accountability for actions in theory, lab or clinical portions of a course
    b. Tardiness or not wearing proper uniform to clinical
    c. Turning in assigned work late**,** incomplete or not at all
    d. Disrespectful communication with peers, faculty, or administration within on or off campus environments, including electronic environments
    e. Disrespectful communication with patients, peers, hospital staff, faculty within the clinical environment
    f. Reckless, inappropriate, or unsafe behavior that could result in patient harm
    g. Disregard for university/college, nursing program, or clinical partner policies
    h. Disrespectful and inappropriate use of laboratory supplies, equipment or space
    i. Inappropriate cell phone use or any other electronic device that has camera and/or text functions
5. Members of the faculty teaching team, and/or Progression Committee will evaluate each unique situation and determine the amount of any deduction based on situation specifics and severity of breach of professionalism.
6. Dependent upon the severity of the unprofessional accountability or behavior, the student may be required to appear before the Dean of Nursing and Faculty Progression Committee for further action based upon program policy.
7. A student who receives a professional point deduction will be advised on means by which to improve professionalism and will be held accountable for improved subsequent performance.
8. Repeat instances of professional accountability concerns may be referred to the College Dean of Students, Dean of Nursing and/or Faculty Progression Committee for further action, based upon college and program policy.

# III-C. GRADING & EVALUATION POLICY

A grade of "C" or greater in every nursing, medical technology and liberal arts course is required in order to progress in the program and to graduate in nursing.

Nursing courses may be composed of theory, lab, and/or clinical components that will contribute to the successful completion of a course.

## 1. Final Course Grade Policy

**Final course grade is determined using the following grading scale:**

A= ≥ 90-100%
B= ≥ 80-89.99%
C= ≥ 70-79.99%
D= ≥ 60-69.99%
F= ≤ 59.99%.

Grades will NOT be rounded up or curved. All nursing courses are taken for a letter grade. Theory points determine the final course letter grade.
Nursing courses are graded with a high degree of rigor, essential to the role of a baccalaureate-prepared nurse. Students are expected to prepare a minimum of two hours outside of class for each one hour in class time. Attendance is crucial to success.

Basis for grading will be determined within the following criteria. To be successful, the student must:

a. Achieve 70% or greater of the total theory points of a course.
   - Failure to achieve 70% or greater in the theory portion of a course will result in receiving a non-passing grade for the entire course.
   - After achievement of an 80% Pass in the laboratory and/or clinical practicum portions of a course, the theory points determine the final course letter grade
b. Achieve 80% Pass in the laboratory portion of a course.*
   - A Pass is given when 80% or greater of the total laboratory points are received.
   - Failure to achieve 80% or greater will result in receiving a non-passing grade for the entire course.
   - *Failure to achieve 90% on a Clinical Reasoning Calculation Exam within two (2) attempts will also result in a non-passing grade for the entire course.
c. Achieve 80% Pass in the clinical practicum portion of a course.
   - A Pass is given when 80% or greater of the total clinical practicum points are received.
   - Failure to achieve 80% or greater will result in receiving a non-passing grade for the entire course.
d. Program policy does not allow extra credit points to meet course objectives.
e. Students must successfully meet established competency criteria for all Essential Competencies, included in nursing course evaluation criteria, in order to successfully pass the course.

## 2. Permission for Recording

Students must receive permission from faculty to tape lectures or guest speakers in class. This decision will be made on a class by class basis at the discretion of the instructor.

## 3. Completion of Examinations/Quizzes Policy

a. Examinations/Quizzes are expected to be taken at the scheduled date and time. This is inclusive of all exams/quizzes.
   - If unable to take an exam at the scheduled time the student must notify the instructor the day of the exam/quiz by MSB email or voice mail to report the absence and determine a date and time a make-up exam may be taken.
   - Quizzes may/may not be made up at the discretion of the faculty, per individual course requirement.
   - **Make-up exams/quizzes must be taken within one week of the original exam date.**

b. A student will be allowed to take one quiz **OR** exam late per course, following the late exam policy. Any subsequent quizzes or exams missed by this student will result in a grade of zero. Some quizzes and/or exams may not be made up. See individual course addendum.

c. An alternative version make-up exam/quiz may be given.

d. **All late exams/quizzes will automatically result in a seven percent (7%) deduction of the total possible points of the exam/quiz.**

e. Not taking a rescheduled late exam (make-up exam/quiz if allowed) at the arranged time will result in a grade of zero (0) points for the exam.

f. A student arriving late to an exam/quiz will only have the remaining time left to finish the exam.

g. Early exams and/or quizzes will not be given.

h. Vacations and work schedules do not constitute an acceptable reason for taking an exam late. This includes final exams.

i. No exams/quizzes may be repeated.

j. Students must turn in and/or electronically submit all exams when the finish time is called by the faculty.

k. Students will receive grades for exams, assignments and courses through criteria established by the instructor. Grades will be posted to CampusConnect for student access and to maintain confidentiality. Students are not to call the nursing office requesting information regarding grades.

l. Refer to ATI section of this Resource Manual for ATI Exam procedures.

## 4. Submission of Written Assignment Policy

a. All theory written assignments, skills lab written assignments, and clinical written assignments are expected to be submitted on the assigned due date and time per course addendum and program policy. Papers may be submitted via CampusConnect or as a hard copy via instructor directions and course policy. CampusConnect will record the date and time the paper was submitted. All papers

and assignments must be submitted for evaluation. Refer to "Clinical Section" in this Resource Manual for clinical paperwork requirements.

b. Failure to comply in meeting due dates and time will automatically result in a **three percent (3%) per calendar day deduction** of the total possible points on all written assignments. **No exceptions will be made to this policy.**
c. Students should save or retain a copy of all written papers/assignments for a course.
d. All papers are to be individually researched and prepared, unless specific instructions state they may be completed in cooperation with others.
e. All papers must be word-processed unless otherwise specified. Papers are expected to be scholarly in nature and should reflect professionalism. Papers should be word processed using 11-12 font, double-spacing, one inch margins, single-sided and utilize APA format in referencing throughout.
f. All hard copy documents are to be stapled together and submitted as a unit.
g. To be credible, a writer must demonstrate a command of grammar, punctuation, spelling, word usage, clarity, and logical progression of thoughts. MSB's Resource Center is available for all students for technical writing skills support. The Nursing Tutor is available for nursing content support.
h. Papers suspected of plagiarism will be subject to investigation. Refer to Nursing Code of Conduct Section III-K. in this manual.

## 5. Incomplete Grade Policy

Incomplete grades will be given in nursing courses only upon approval of the faculty, Dean of Nursing, and Dean of Students. Incomplete grades are approved for extreme situations, and only if the student may reasonably complete course requirements within the required deadline. Incompletes will not be given due to absence days in a clinical rotation.

See Program Progression and Graduation Requirements section of this manual for more information.

## 6. Essential Competencies Policy

a. Students must successfully meet established competency criteria for all Essential Competencies included within a nursing course in order to pass the course.
b. Each course syllabus identifies the Essential Competencies included within the content.
c. Criteria for successful completion of Essential Competencies are included in each course addendum and/or assignment instructions.
d. Written Essential Competencies must be passed at 70%. Skill Essential Competencies must be passed at 80%.
e. Students may be allowed one (1) rewrite on an Essential Competency paper per course criteria. The paper must meet stated paper criteria on the rewrite. Upon meeting of criteria the student will receive the minimum score attainable to meet criteria as the final grade for the Essential Competency.
f. Not meeting passing standards on an Essential Competency will result in a failing grade for the entire course.

g. Students are encouraged to meet with faculty to clarify criteria for successful completion of Essential Competencies as needed.
h. Essential Competency papers that are turned in later than six calendar days forfeit the opportunity to rewrite the paper. This will result in failure of the paper and failure of the course.

## 7. Clinical Reasoning Calculation Exam Policy

a. Clinical reasoning calculation exams must be passed at 90% proficiency.
b. One re-test will be allowed on clinical reasoning calculation exams.
c. Students not passing a required clinical reasoning calculation exam at 90% within two (2) attempts will receive a failing grade for the entire course.
d. Students may use a calculator during clinical reasoning calculation exams. Cell phone or other electronic devices are not permitted.
e. Exams may be paper & pencil or computerized.
f. All scratch paper must be turned in to faculty at the completion of a clinical reasoning calculation exam.
g. Students not meeting competency at 90% within two (2) attempts may not be able to progress in course/s with a clinical component requiring clinical reasoning calculation skill.
i. Third attempts at clinical reasoning calculation competency will NOT be given. **No exceptions will be made to this policy.**

## 8. Competency Test-Out of Technical Skill / Nursing Interventions Policy

a. All nursing intervention skills included in a course must be passed at proficiency within two (2) attempts. (Pass/Fail)
b. Students not passing a competency test-out at proficiency within two (2) attempts will receive a failing grade for the entire course.
c. Competency criteria are specified for each skill within course/unit content.
d. Third attempts at nursing intervention skill test-outs will NOT be given. **No exceptions will be made to this policy.**
e. The student is expected to come prepared to test at the scheduled time.
f. Second attempts will be scheduled after the student has demonstrated remedial work in preparation for the attempt.
g. Competency testing may occur outside of scheduled lab hours.
h. Nursing intervention technical skill test-outs that are Essential Competencies included in the lab and/or clinical portion of a course must be passed at established criteria to receive a passing grade in the course.
i. The student will sign up for a testing time per faculty criteria.
j. A late arrival or absence for a scheduled competency skill test-out, for any reason, will be counted as an attempt. **The clock in the nursing lab is the only clock to be used to determine a timely arrival for a scheduled test-out time. No exceptions will be made to this policy.**

## 9. Clinical Grading Policy

**Clinical Competency:**

1. The student is evaluated each clinical day based on course competencies and performance objectives. Specific competencies will be given to students the first day of the clinical portion of the course.
2. A score is assigned for each competency and performance objective based on the rating scale in number three (3).
3. A score of 80% must be achieved to pass the clinical performance portion of the course. (See Grid.)
    a. On a 4.0 scale student must receive 3.0 or greater summative score to achieve 80% competency.

        90-100% A = ≥ 3.60 - 4.0
        80- 89.99 % B = ≥ 3.00 – 3.59

    b. A score of "1" or "0" in any competency or performance objective on the last day of patient care will result in a failing grade for the course regardless of scores received on other competencies or performance objectives.

**Clinical Competency Evaluation Grid**

| | |
|---|---|
| 4<br>(90-100%) | Performance exceeds expectations for this level of learning.<br>Performance is consistent.<br>Performs primarily without reminders and/or cueing. Is proficient. |
| 3<br>(80-89.99%) | Performs as expected for this level of learning.<br>Performance is consistent and/or improving.<br>Requires occasional reminders and/or cueing for proficiency. |
| 2<br>(70-79.99%) | Concerns over performance.<br>Potential exists to be unsafe.<br>Performance is inconsistent.<br>Requires frequent and multiple reminders and/or cueing for proficiency. |
| 1<br>(60-69.99%) | High risk for unsafe performance.<br>Safe only with supervision.<br>Requires constant reminding and/or cueing. |
| 0<br>(59.99 % and Below) | Unsafe.<br>Unable to perform even with reminding and/or cueing. |

4. Clinical performance will be reviewed with the student weekly, and as needed, as a formative clinical evaluation.
5. An evaluation will occur midway during the clinical experience, alerting the student to progress towards meeting clinical objectives.
6. Clinical paperwork must be turned in to meet clinical course requirements. All required papers/forms must be turned in on time, and be complete at the time of submission. Clinical paperwork submitted late will result in a score of "1" in the components of clinical evaluation that require evaluation of written work to determine competency.
    a. Per clinical course grading criteria, major papers may be included as part of the theory course, contributing to the overall final course grade.
7. No incompletes will be given for the clinical component of a course.
8. A remediation plan and clinical performance contract will be initiated for
    a. any patient safety concerns related to student performance.

b. a score of “1” or “0” in any competency or performance objective, prior to the last day of patient care.
c. a score of less than 80% on any given clinical day.
d. an average score of less than 80% after midway through the clinical experience.

9. A remediation plan will not be considered if the student receives a“1” or “0” the last day of patient care. The student will receive a failing grade for the course.
10. Essential Competencies included in the clinical component of the course must be passed at established competency criteria to receive a passing grade in the course.
11. A student may not, under any circumstances, perform an invasive nursing intervention or administer medications, including intravenous therapy, without the MSB instructor or facility staff nurse/preceptor being present.
    a. A student who does any of the above without the instructor or facility nurse/preceptor present will be considered unsafe, will be removed from clinical, and will be required to meet with the Dean of Nursing and Progression Committee.
    b. This may result in failure of the clinical experience and course and potential exit from the program.
    c. RN 413 preceptorship clinical experiences may allow for independent action of the student after safety has been determined and per program and facility policy. Student is to refer to and follow the clinical performance guidelines in the RN 413 course syllabi and addendum.
    d. See Medication Administration and Error Policy and Protocol under Clinical Policies in section III-F.

## 10. Performance Contract

a. Students may be placed on a Course Remediation Plan and/or Clinical Performance Contract, for unsatisfactory progress and unsafe or potential for unsafe practice in the course and/or clinical setting. The clinical setting is defined as any off campus learning experience required within course content or as a graduation requirement. Applied/Service Learning experience is included in this definition.
b. The instructor and student will meet to discuss the performance concerns and write the Performance Contract.
c. The Performance Contract will include criteria for the student to achieve, instructor/student conferences to evaluate progress, time frames and dates of completion of the Performance Contract.
d. If student performance does not improve, or new issues of concern arise, the student will receive a failing grade for the course.
e. A Remediation Plan and/or Performance Contract will not be considered if the student receives a “1” or “0” the last day of patient care of any off-campus clinical experience, including Applied/Service Learning. The student will receive a failing grade for the course.
f. A performance contract may extend into future courses including clinical courses dependent upon the nature of the concerns for student performance. Extension of a performance contract is designed to ensure continued evaluation of the student to determine competency and consistency in performance. In situations of unsafe performance, a contract will not be extended, and the student will receive a failing grade for the course in which clinical is a component.

# III-D. RETAKING COURSES / RE-ENTRY TO PROGRAM POLICY

1. No RN course may be repeated more than once.

2. If any component of a nursing course is not successfully completed, the ENTIRE course must be repeated and completed with a grade of "C" or greater on the next attempt. This includes lecture/theory, lab and/or clinical components of a course as applicable.

3. Students are not allowed to automatically repeat a nursing course. Any student failing or withdrawing from a nursing course must follow program policy.

4. Students who withdraw, fail "F", or receive a grade of "D" in one or more nursing courses in one quarter will receive notification stating they are on probation and are required to schedule an appointment with the Dean of Nursing and Progression Committee regarding the student's status and/or progression within the program.

5. Participation in Progression Committee meetings will be limited to include the student, Dean of Nursing, Nursing Department Chair, Dean of Students, and Nursing Faculty.

6. Eligible students will not be allowed to reregister for a failed course or any other nursing course until approval is given by the Dean of Nursing and Progression Committee.

7. **Students required to repeat a course due to a withdraw or failing grade will be considered a re-entry student. Students may re-enter the program one time only. Re-entry will be based on course sequencing and space available.**

8. Due to the sequential nature of the nursing curriculum:
   a. Students will be able to re-register for a failed nursing course the next time it is offered, dependent on space and availability, especially as it relates to clinical.
   b. Based on pre-requisites, the student may not be able to re-enter and progress in other nursing courses until the failed course is successfully repeated.
   c. Graduation will be delayed, based on the course(s) required to be repeated.
   d. The student may not be able to progress in general education or RN designated courses if a grade of "W" (Withdraw) or a letter grade of "D" or less is received in a general education course that is a pre-requisite.

9. The program and college reserves the right to deny approval for re-entry to the program based on re-entry program criteria and compliance with completion of re-entry conditions by the student.

**10. Process for Student to Petition for Removal from Probationary Status due to an Academic Non-Passing Grade in a Nursing Course**

Student may petition to be removed from probationary status when the following has occurred:

1. The student has received a final grade of "C" or better, on the first attempt, in six RN courses following the course in which a non-passing grade of “D” or “F” was received, including successful completion of the course originally failed.

2. The student will initiate the process to be removed from probationary status by submitting a "Petition to be Taken Off Probation" to the Dean of Nursing.
   - Withdraws may be counted as a first attempt and will be reviewed on an individual basis by the nursing progression committee
   - The format for a petition will be available in the nursing office from the Nursing Project Coordinator

3. The Dean of Nursing will review the petition and forward the petition to the faculty progression committee as needed for review.
   - The student may be asked to appear before the faculty progression committee if there is need to validate or clarify Information.

4. The Dean of Nursing will notify the student of the decision of the committee in person, via phone or in writing.

5. Please note that a student may be placed on Academic Probation again if a future nursing course is not passed on the first attempt.

## III-E. CONDITIONS FOR EXIT FROM THE NURSING PROGRAM

Nursing program students are allowed one re-entry to the program. Students required to repeat a nursing course due to a withdraw or failing grade will be considered a re-entry student.

Students will be permanently exited from the nursing program if they have failed or withdrawn from:

1. The same nursing course more than once.

2. Two different RN courses over more than one quarter, including a course previously failed and repeated with a passing grade.

Re-entry may be approved or denied by the Nursing Program.

The Nursing Program and college reserves the right to deny approval for re-entry to the program based on re-entry program criteria and compliance with completion of re-entry conditions by the student.

**Nursing faculty, including the dean of students, has the discretion and authority to summarily remove a student from clinical for unsafe performance or for violation of the Code of Conduct at a clinical site.**

**The nursing program, including the dean of students, reserves the right to exit a student from the program at any time for unsafe or unethical performance.**

# III-F. NURSING PROGRAM CLINICAL POLICIES

## 1. Overview

A Globe University clinical instructor will supervise nursing students in the clinical setting. The clinical instructor is responsible for making appropriate assignments for the student, supervising the care delivered, and providing clinical instruction per course requirements. Clinical instructors will provide written and verbal feedback regarding student performance as per program policy and per course syllabus and addendum. Faculty will administer the final clinical evaluation with input from the appointed hospital or agency Registered Nurse preceptor as appropriate.

A Globe University clinical faculty will be in charge of all communication with the clinical site, director of education, supervising nurse and/or preceptor.

The Dean of Nursing and/or the Clinical Coordinator will identify all clinical sites and develop written contracts with hospitals, agencies, and health facilities**. Nursing students are not allowed to identify their own clinical sites unless as stated in course objectives**. Students will be required to attend clinical at multiple sites throughout the metro area which will require reliable transportation. Clinical hours may start as early as 5 AM and end as late as 12 midnight including weekends, depending on clinical availability and student assignment. Some internships may include overnight shifts.

The only title which is to be used when acting in the capacity of a student in the Nursing Program is Globe University Student Nurse (MSB SN). Program students who have other titles (e.g., LPN, RT, MD, PhD, JD) as part of their working lives may not use these titles when functioning in the capacity of an MSB Nursing Program student and/or under the auspices of the Nursing Program.

## 2. Student Responsibility for Clinical Readiness

A. Student has a completed Health Physical Form, Immunization Form, current criminal background check cleared to attend clinical, and current CPR certification for the Health Care Provider on file in the nursing office. The student may not attend clinical if immunizations, tuberculin testing, health forms, background check and CPR are not current. Students who do not meet this requirement will be counseled to drop or withdraw before the date on the college calendar indicating the last day to drop or withdraw. Based on clinical site policy, students may need proof of negative TB/chest x-ray testing or urinalysis drug screening more frequently than on an annual basis. **Any student who has not turned in the required paperwork may have a hold on their account and will not be able to register for the following semester until all required paperwork is turned in.**

B. Student has successfully completed all nursing and general education courses that are prerequisites for a course requiring a clinical component for successful completion.

C. Student has successfully completed, or is currently enrolled, in all nursing and general education courses that are pre or co-requisites for a course requiring a clinical component for successful completion.

D. Periodically throughout the curriculum students may be required to independently research and obtain clinical experiences to fulfill clinical hours based on course objectives (ex: RN 156 Health Promotion Across the Lifespan). Such experiences must be approved by the course faculty before the student begins the experiences, this includes Applied/Service Learning hours. This does not apply to RN 405, 408 or 413.

## 3. Clinical Attendance Policy

A. Nursing students must fulfill the following requirements:
   1. Complete all required hours of clinical experience and/or simulated lab hours in order to successfully complete each nursing course that has a clinical/simulation component. Clinical hours must be completed within the quarter when the clinical course is offered and in the specific nursing program course sequence.
   2. If clinical/simulation hours are not completed successfully, the student will fail the course and will be required to complete the entire course, upon a space available basis, when it is next offered within the curriculum. The student will have to pay tuition to repeat the course.
   3. If clinical/simulation hours are not completed successfully the student will not be allowed to progress within the nursing curriculum due to the sequential nature of the nursing courses.

B. Students must attend a MANDATORY orientation meeting prior to beginning each clinical experience. Failure to do so will result in the student being required to withdraw from the course or, if the student does not withdraw, receive a failing grade for the course.

C. Students may not practice independently, regardless of any other roles or credentials the student may have, while performing as a nursing student in the program. Students are supervised by MSB nursing faculty or designee at all times while in the program.

D. Nursing program policy will not excuse students from class or clinical experience due to employment schedules. Students are expected to commit to scheduled hours and courses. As a safety issue for clinical performance, students are expected to come rested and prepared to perform safely.

E. All make-up assignments may occur in the simulation lab which must be scheduled with the Simulation Lab Coordinator; or as determined by the clinical instructor. All make-up must be completed prior to the end of the quarter.

F. Missing two days of clinical, for any reason, will require that the student receive a non-passing grade for the course.

G. Students must maintain a professional appearance while participating in clinical experiences. See “Nursing Program Uniform Policy” in this Manual for specific guidelines.

H. A student coming to clinical in violation of the dress code will be sent home and the day will be counted as an absent day, with the resulting consequences. If the student has already been absent due to illness or family emergency the student will receive a non-passing grade for the course.

I. Students not in compliance with Health Physical Form, CPR, background check, immunizations, and/or TB testing requirements will NOT be allowed to attend clinical. The student will need to drop, withdraw, or if it is past the date, or a student chooses not to withdraw, the student will receive a grade of “F” for the course.

**Nursing faculty, including the dean of students, has the discretion and authority to summarily remove a student from clinical for unsafe performance or for violation of the Code of Conduct at a clinical site.**

**The nursing program, including the dean of students, reserves the right to exit a student from the program at any time for unsafe or unethical performance.**

## 4. MEDICATION ADMINISTRATION AND MEDICATION ERROR POLICY

Globe University Bachelor of Science in Nursing Program Standards related to Student Administration of Medication in the Clinical Setting

The nursing program adheres to established guidelines for safe and ethical administration of medication in the clinical setting as established by professional nursing standards and guidelines:

1. Joint Commission Accreditation Standards
2. The American Association of Colleges of Nursing *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008)
3. American Nurses Association Scope and Standards of Practice (2001)
4. American Nurses Association Code of Ethics (2001)
5. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
6. The “rights” of medication administration cited in nursing literature and textbooks.
7. Policies of the clinical partner facility related to medication administration by non-licensed nursing students.
8. Faculty and/or the facility staff nurse must be present with the student during all steps of the medication administration process.

**The nursing program utilizes the following concepts regarding electronic signatures with students in the clinical setting.**

A signature serves three main purposes:

- **Intent:** an electronic signature is a symbol that signifies intent, such as confirmation that the signer reviewed and approved the content, or the signer authored the document and approves the content.
- **Identity:** the signature identifies the person signing.
- **Integrity:** a signature guards the integrity of the document against repudiation (the signer claiming the entry is invalid) or alteration.

**The nursing program follows Joint Commission Accreditation Standards related to e-signatures.**

The Joint Commission accepts the use of e-signatures in hospitals and ambulatory care facilities, according to standard RC.01.02.01 in the *2009 Accreditation Manual for Hospitals and Ambulatory Care Facilities.* The elements of performance require that:

- Only authorized individuals make entries in the medical record.
- The hospital or organization defines the types of entries in the health record made by non-independent practitioners that require countersigning, in accordance with law and regulation.
- The author of each medical or clinical record entry is identified in the health record.
- Entries in the health record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.
- The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.

To ensure safe and ethical practices for electronic signatures and documentation related to medication in the clinical setting for faculty and students the program follows:

1. Established policies of the clinical site related to faculty verification of student documentation through an electronic co-signature. Clinical site polices take precedence over program protocol when there are differences, unless the program determines policies may be unsafe related to student status.
2. E-signature protocol:

a. Faculty and/or staff nurse must be in the presence of the student, with each medication administration, to attest to the student action related to the documentation and may verbally give permission to assign the faculty member and/or staff nurse's e-signature when in the presence of the student.
b. At no time may a student assign a faculty member or staff nurse e-signature to a medical record or document without the faculty member or staff nurse being physically present and giving verbal permission.

**The nursing program utilizes the following concepts to determine unsafe medication administration practices by students in the clinical setting.**

1. Student is not able to demonstrate knowledge of the medication to be administered related to
    a. Classification
    b. Safe dosage for individual patient according to age and medical diagnosis
    c. Applicability of route
    d. Potential complications, adverse actions or drug interactions
    e. Implication for use for individual patient according to medical diagnosis
    f. Desired action of medication
    g. Assessment data required prior to and after administration of medication
2. Student does not follow the "rights" of medication administration.
    a. Right patient
    b. Right assessments (pre and post administration)
    c. Right medication
    d. Right dose and route
    e. Right time
    f. Right documentation
    g. Right follow-up
3. Student does not perform three safety checks to ensure correct medication and dosage.
4. Student does not utilize two patient safety identifiers at the point of patient contact prior to administration of the medication. Unless contraindicated, one identifier is the patient wristband.
5. Student does not accurately document the administration of medication, utilizing the MAR, electronic medical record or other formats used by the clinical facility.
6. Student does not safely utilize electronic medication administration protocol.
7. Student does not follow timeline guidelines to ensure a medication is given on time.
8. Student does not follow policy related to controlled substances.
9. Student administers medication without faculty or staff nurse present.
10. Student does not confirm medication administration responsibility and accountability with staff nurse by time specified at the beginning of a clinical shift.
11. Student does not recognize or accept accountability for actions related to safe medication administration.

**Any of the above indicators may result in one or more the following, dependent on the individual situation.**

1. Counseling of student related to performance.
2. Placed on a clinical performance contract with stipulations for improvement.
3. Referral to nursing tutor for remediation.
4. Assignment of a medication error to the student.
    a. To protect patient safety, a faculty member will stop a student from committing an actual medication error. If a student is stopped by the faculty prior to administration of a medication to avoid an actual medication error, and the student did not self-correct, the incident will be considered a “near miss” medication error.
    b. The faculty will utilize the Medication Administration Error Decision Making Tree (NCC MERP) to determine type and severity of “near miss” error.
    c. Based on the individual incident and/or number of incidents the student may:
        i. Be counseled
        ii. Be placed on a clinical performance contract with stipulations for improvement
        iii. Be referred to the nursing tutor for remediation
        iv. Be required to meet with the program progression committee and may:
            1. Receive a failing grade for the clinical component of the course and/or
            2. Be exited from the program

**In any instance, the nursing program, including the Dean of Students, reserves the right to summarily exit a student at any time for unsafe or unethical performance or violation of the Code of Conduct.**

## 5. CLINICAL REQUEST POLICY

**a. General clinical protocols**

- Clinical requests are the responsibility of the Nursing Project Coordinator (see registration policies). The request forms are distributed as appropriate each quarter via MSB e-mail. The program makes every effort to grant first and/or second choice of student request when possible.
- Learning experience sites and times are subject to change based on confirmation of requests by clinical partners, faculty availability, and other circumstances.
- Each student is personally responsible to ensure all clinical requirements have been met per program and facility policy and course addendum.
- All experiential learning hours and assignments should be completed by Week 10 to ensure completion of requirements.
- No Incompletes will be given to complete clinical requirements

**b. Specific course clinical protocols**

- ***RN 152: Nursing Foundations***
  - This 30-hour learning experience occurs within a long-term care or transitional care setting during Weeks 8-10 of the quarter.
  - Clinical request forms will be emailed to students by Week 2 of the quarter specifying sites and options, if applicable.

- ***RN 156: Health Promotion Across the Lifespan***
  - This is a self-directed, 30-hour learning experience as identified in course addendum.

- ***RN 204: Provider of Care***
- ***RN 302: Provider & Coordinator of Care***
- ***RN 305: Care of Children***
- ***RN 306: Care of the Child-Bearing Family***
- ***RN 401: Behavioral Health Care***
  - These 60-hour learning experiences occur primarily in acute care settings at various times throughout the quarter.
  - Clinical request forms will be emailed to students by Week 7 of the preceding quarter, specifying sites and options for first and second choices, if applicable.
  - Students are usually notified within one week of submission.
  - Students will be provided information on site-specific orientation and training, which must be completed by Week 10 of the preceding quarter.

- ***RN 404: Holistic End-of-Life Care***
  - This 30-hour mentorship learning experience occurs in hospice care settings at various times throughout the quarter.
  - Students will be assigned a clinical site by the Clinical Coordinator.

- ***RN 408: Community Health Nursing***
  - This 90-hour mentorship learning experience occurs in multiple care settings at various times throughout the quarter.
  - This experience can include service learning, simulation, and on-site community health experiences.
  - Students will be assigned a clinical site by the Clinical Coordinator.

- ***RN 405: Leadership and Management in Nursing***
  - This 60-hour mentorship learning experience occurs in multiple care settings at various times throughout the quarter.
  - This experience can include service learning, simulation, and on-site leadership/mentorship experiences.
  - Students will be assigned a clinical site by the Clinical Coordinator.

- ***RN 413: Nursing Internship/Professional Role Development***
  - This 120-hour learning experience can occur in multiple care settings at various times throughout the quarter.
  - Students will be assigned a clinical site and preceptor by the Clinical Coordinator.

c. **Protocol for site-specific requests by students for RN 405, RN 408, and RN 413:**
   - The Clinical Coordinator is responsible for initiating all communication and requests regarding clinical learning experiences.
   - In the event that a student wishes to request a specific site and/or preceptor, that student must first communicate with and relay the information to the Clinical Coordinator in advance *(six months preferred, but absolutely no later than 3 months before the quarter of the learning experience.)*
   - The student is NOT to pursue or discuss the specifics of the learning experience with a potential site, per the request of clinical partners. Breaking this policy may jeopardize the nursing program's relationship with clinical partners and may result in the loss of Professional Accountability Points and/or meeting with the Progression Committee.
   - There must be a valid contract in place with any clinical partner before the first day of the quarter in which the learning experience would occur. If contract is not complete, then the student will be assigned an alternate experience by the Clinical Coordinator.

## III-G. NURSING PROGRAM UNIFORM POLICY

Globe University identification badge and (if required) the clinical site badge must be worn at all times. Identification badges must be clipped to the shoulder area or hung from a lanyard. MSB photo ID must state Nursing Student and state first name and last initial only.

The dress code may be determined further by the clinical site.

**Guidelines for attire in the clinical area**

Wearing uniforms will encourage students to take pride in their profession, enhance professional appearance, and support professional behavior. The nurse, as a health professional, has certain responsibilities regarding the uniform. The rationale for the uniform involves:

- Cleanliness
- Freedom of movement and safety
- Identification of personnel
- Professional appearance

1. The student must wear the complete uniform when a uniform is required for clinical experiences and simulation laboratory experiences or competency testing.
2. The official Globe University Nursing Program uniform is **purchased through the college** and consists of:
   - Navy blue top with Globe University nursing patch.
   - Navy blue uniform pants or straight skirt: **no bell bottom pants with a slit**. Pants must be hemmed or cuffed and not able to be walked on. Skirts must be below the knee.
   - Additional, warm-up navy blue or white jackets or lab coats are allowed.

- Only a plain, white t-shirt may be worn under top: Must not be ruffled or adorned. T-shirt may be long sleeved with cuffs able to be pushed up for cleanliness during patient care.
- Clean predominantly black or white shoes with black or white shoelaces. These shoes can only be worn while on clinicals/practicums. Clogs, sandals, and moccasins are not acceptable. Shoes must be clean at all times.
- Globe University identification badge and (if required) the clinical site badge must be worn at all times. Identification badges must be clipped to the shoulder area or hung from a lanyard and in plain sight.
- Hose/socks must be white or neutral in color.
- Cultural head dress for clinical must be white or black in color and no longer than shoulder length. Headdress should be pinned back and drape of garment should not be flowing as to compromise student or patient safety in the clinical site.

3. Clothing should be loose enough to permit freedom of movement and of sufficient length to maintain modesty.

4. Undergarments must be skin toned. Bikini, high cut or thong underwear cannot be worn.

5. Hair must be clean and styled in a manner which does not obstruct the visual field or allow contamination of clean or sterile areas. Long hair should remain pulled back from the face throughout the clinical experience and must not hang down in a manner contaminating clean or sterile areas or brushing against patient. Solid colored headband may be worn. No decorative headwear. Extremely long hair may require pinning up off of collar to maintain cleanliness for patient care.

6. Jewelry: Small post earrings, a wedding ring and watch are allowed. Dangling earrings and piercings, long necklaces and large rings are not only unprofessional but also endanger patient safety, and are prohibited from wearing on clinical. Articles which endorse a particular belief system or political candidate are not permitted. Note: some clinical facilities may have more restrictive policies (i.e., no jewelry allowed).

7. Visible tattoos are not permitted. Tattoos must be covered by appropriate uniform or professional clothing attire as much as is possible.

8. Fingernails should be short in length. No artificial nails due to infection control reasons. Nail polish is not allowed at clinical sites.

9. Be clean and odor free (and facial hair trimmed or neatly shaven as appropriate). The use of perfume or aftershave lotions is not allowed due to risk of allergic responses.

10. Nursing uniforms must not be worn on campus for infection control reasons, unless required by clinical simulation lab or immediately prior to attending a required clinical shift.

11. Professional attire is expected whenever you are representing GU/MSB.

Some clinical situations and activities may require the student to wear business attire with or without wearing a lab coat. The following are general examples of appropriate attire:

- **Women**
  - Tailored dress
  - Skirts *(skirt length - knee length or below)*
  - Blouse or shirts that modestly cover cleavage
  - Slacks/ khaki pants
  - Shoes - comfortable low heeled pumps, loafers or boots *(no flip flops, sneakers or sandals)*

- **Men**
  - Suit/jacket/blazer/sweater
  - Shirt - traditional shirt with collar/ polo style
  - Slacks/Chinos or Dockers
    - Tie *(if appropriate to situation)*
    - Shoes - dress/loafers/lace-ups *(no flip flops, sneakers or sandals)*

Unacceptable clothing for either sex includes jeans/western cut pants, hooded sweatshirts, sweatshirts, shirts of underwear type, see-through clothing, sleeveless shirts or any clothing that exposes a bare midriff, back, chest or underwear.

12. A student coming to clinical in violation of the dress code will be sent home and the day will be counted as an absent day, with the resulting consequences. <u>If the student has already been absent due to illness or family emergency the student will receive a non-passing grade for the course</u>.

# III-H. HEALTH EVALUATION

Nursing students must provide verification of the following: evidence of immunity to measles, mumps and rubella by vaccination or other medically accepted criteria, current immunity status regarding Varicella (chicken pox), current immunity status of Tetanus, documented completion of a negative tuberculosis skin test (Mantoux) or negative chest x-ray, or QuantiFERON®-TB Gold test (QFT-G), and Hepatitis B. Refer to Health Physical and Immunization Form.

(As a nursing student it is your responsibility to disclose, as applicable, to the Fairview Health Care System if participating in exposure prone procedures, that you have tested positive for the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV).)

Refer to College policy regarding Bloodborne Pathogens.

All nursing students will acknowledge that they have received and read information on Hepatitis A, Hepatitis B and Hepatitis C.

**Health Requirements**

- Students must submit a completed Health Physical Form and Immunization Form
- Students must present annual evidence of a negative Mantoux or negative chest x-ray, or QuantiFERON®-TB Gold test (QFT-G). Students with a previous positive mantoux result are required to provide documentation of a negative chest x-ray. Some clinical sites require a negative Mantoux within 6 months of participating in a clinical experience, or substance/drug testing.
- Some clinical sites may require drug/substance testing prior to attending clinical at the site. A student who does not comply or meet standards will not be allowed to attend clinical.
- Students will NOT be allowed to attend clinical without complying with these health requirements.
- Students must maintain good health throughout the program in order to meet the expected course outcomes.
- A student who is unable to meet clinical requirements due to health issues must consult a health professional for appropriate evaluation and/or treatment and meet with the Dean of Nursing and Progression Committee for approval to continue in the program.
- Students must meet the policy requirements of the health agencies to which they are assigned. Students who refuse to comply with the policy requirements of the health agencies to which they are assigned will be counseled to withdraw before the date on the college calendar indicating the last day to withdraw. If it is past this date or a student chooses not to withdraw, the student will receive a grade of “F” for the course.

## III-I. HEALTH & PERSONAL APPEARANCE ON CAMPUS

Each student entering Globe University has a personal obligation that extends beyond class attendance. Personal appearance is important in the total professional development of the student. Throughout the program, future employers will be visiting the school as invited speakers, evaluators, and/or observers. Thus, a student's appearance will reflect his/her readiness to join today's workforce.

Due to OSHA federal regulations, laboratories enforce a strict dress code. Students must adhere to these guidelines when meeting in these rooms regardless of their program. OSHA regulations mandate that no shorts, sandals, or sockless feet be allowed in areas of biohazardous exposure.

Failure to comply with health and professional appearance standards may result in suspension from school or exit from the program.

## III-J. STUDENT NURSE MALPRACTICE INSURANCE

Nursing Students are covered under the insurance policy of Globe University when on clinical and while representing the nursing program. However, it is advisable that that nursing students carry their own additional personal liability insurance.

One option to explore for professional liability insurance is the Nurses Service Organization. For more information, you may visit: www.nso.com/nsna

# III-K. CODE OF CONDUCT

**NURSING STUDENT CONDUCT**

The nursing program believes that each person is accountable for his/her individual behavior as it impacts the learning environment or imposes on the rights, safety and freedoms of others. Unacceptable behaviors may serve as a basis for disciplinary action, which could result in reprimand, probation or exit from the nursing program and/or college. Students are held accountable to exemplify behaviors suitable to the role of the professional nurse as exemplified in the "*Essentials of Baccalaureate Education*" (AACN, 2008) and as outlined by the "Code of Ethics for Nurses" (ANA, 2001)

## 1. Personal Integrity

Personal integrity is an essential attribute of the individual as well as a professional role behavior. The following are examples of unethical and unprofessional behaviors.

Students who commit any of these behaviors will be required to appear before the Dean of Nursing, the Dean of Students, and a committee of faculty for disciplinary action. These examples include, but are not limited to:

- Cheating or academic dishonest behavior of any kind during theory, lab or clinical assignments, exams or competency test-outs
- Plagiarizing of any written assignments
- Submitting work that is not your own
- Assisting other students in dishonest acts
- Violating patient's rights or confidentiality
- Violating school or clinical facility policies
- Falsifying student or patient medical records
- Withholding or falsifying information during clinical and community experiences
- Not being truthful regarding patient care or clinical performance, not reporting errors or omissions in patient care
- Not accepting responsibility/accountability for own behavior
- Harassing students or faculty in or outside of the classroom by verbal, e-mail or telephone communication
- Utilizing verbal, written, social media, electronic media, or email communication that is of a slanderous nature regarding other students, faculty, administration or staff of the college.

Please refer to the MSB College Catalog and/or Handbook (Harassment and Conduct Policies) for additional clarification of disruptive behavior and consequences.

**Any student who has alleged misconduct will be required to appear before the Code of Conduct Committee. Participants will be limited to the student, the Dean of Nursing, Nursing Department Chair, the Dean of Students and Faculty Committee. Any incident of alleged misconduct may also be subject to an investigation by the College as deemed appropriate.**

## 2. Test Taking Rules

- NO hats, caps, hoods, or visors
- NO food or beverages
- Students cannot leave the testing room without explicit permission from the instructor.
- All cell phones and electronic devices must be OFF and OUT OF SIGHT
- NOTHING ON DESK but pen/pencil, eraser, and papers provided by instructor.
- Students are responsible to keep answers hidden from view (whether on paper or computer screen). Use paper provided by instructor to cover answers if necessary.
- The instructor will make "rounds" during the test
- Students are to keep eyes focused on own test, wandering eyes may result in removal of test and a score of 0 points being awarded.
- Absolutely no talking or communicating for ANY reason to another student. It will result in removal of test and a score of 0 being awarded.
- Write on paper provided only. No writing on palms, body parts, or desk for any reason.
- Note: The instructor reserves the right to tell any individual student they must sit alone at a desk to take tests. This may occur before or during a test, there will be no explanation or discussion regarding the decision. If a student does not comply, a score of 0 points will be awarded.

## 3. CODE OF CONDUCT POLICY (ON EXAM TAKING / COMPETENCY TESTING / CLINICAL PERFORMANCE / ASSIGNMENT INTEGRITY)

A nursing student determined to have been dishonest or commit unethical behavior on an exam, skill test-out, assignment and/or clinical performance will receive the following consequences:

1. The exam or assignment will be invalidated. The student will receive a zero (0) for the exam or assignment. The student will NOT be allowed a retake exam or submission of an alternate assignment.
2. The student will appear before the Dean of Nursing, Dean of Students and Progression Committee and may be placed on probation contract or exited from the Nursing Program per decision of the Dean of Nursing Dean of Students and Progression Committee.
3. The student may fail the course in which the exam or assignment, clinical proficiency, or competency test-out was a criterion for completion based on the decision of the Progression Committee.
4. Unethical clinical performance will result in failing the entire course and may be grounds for exit from the program.

**Nursing faculty, including the Dean of Students, has the discretion and authority to summarily remove a student from clinical for unsafe performance or for violation of the Code of Conduct at a clinical site.**

**The nursing program, including the Dean of Students, reserves the right to exit a student from the program at any time for unsafe or unethical performance.**

## STUDENT AFFIRMATION FORM

**_____I understand that as a nursing student I am a member of a profession that places me in a position of confidence requiring the utmost discretion and professionalism to protect those with and for whom I work. I acknowledge that as a member of the nursing profession I have a responsibility to act in a manner consistent with the essential attributes of the profession. In this regard:**

_____I agree to protect the privacy of faculty, peers, patients and family members of patients by not inappropriately disclosing confidential information about faculty, peers, patients or their family members that is disclosed to me in my capacity as a Globe University nursing student. In addition, I agree not to inappropriately disclose confidential information about my agency or institution that is disclosed to me in my capacity as a Globe University nursing student. I will adhere to HIPAA guidelines.

_____I have/will read the syllabus and addendum of the nursing course I am taking this semester and I understand the criteria established for submission, evaluation and grading of my course work.

_____I agree that I will conduct myself in a manner that exhibits professional values and in accordance with the American Nurses Association (ANA) Code of Ethics for Nurses. (http://www.nursingworld.org/codeofethics)

_____I will maintain and uphold the academic integrity policy of the Nursing Program and Globe University and will not condone or participate in any activities of academic dishonesty including, but not limited to, plagiarism, cheating, stealing or copying another's assigned work, or lying about any situation.

_____I will not recreate any items or portions of any exam/quizzes for my own use, or for use by others nor will I accept or access any unauthorized information related to any exam/quiz during my enrollment in the Globe University Nursing Program.

_____I will sign my own papers and other documents and will not sign any other student's name to anything, including class attendance reports.

_____I will not allow any student access to any of my paperwork for the purpose of copying.

_____I will not discuss or post any information about faculty, peers, patients, family members, or any clinical facility on any electronic venue (i.e. MySpace, Facebook, Twitter, cell phones, etc.). Nor will I leave/save any patient, family, faculty, clinical facility or student information on any open access desktop or hard-drive.

_____I will not discuss peers' comments of a confidential nature outside the classroom.

_____I will adhere to the Social Media Policy as it is written in the Globe University Bachelor of Science Nursing Program Resource Manual.

_____ _____
Student's Signature Date

_____
Student's Printed Name

# III-L. APPEAL PROCEDURE

The Nursing Program believes in effective communication between students, faculty and administration to resolve questions of an academic nature. If a student has a concern about a course, the student must first contact the instructor to voice concerns and seek clarification.

- Grading is the sole prerogative of the nursing instructor and/or Nursing Program policy.
- Concerns regarding exam grades or course requirements must occur within one week of receiving the grade. Appeals regarding course requirements will not be addressed after a final grade has been posted.
- Students are required to meet with faculty to discuss concerns before proceeding with any other steps. Students are to utilize faculty office hours or make a specific appointment.
- The grade review process is limited to numerical error in the calculation of a course grade or in the departure from the method described in the syllabus or this program Resource Manual.
- Nursing Program Policy regarding course grades, progression in the program, and re-entry are listed in this Resource Manual and course syllabi.

**Appeals Regarding Nursing Program Policy**

A student seeking an exception to program policy must make a formal appeal. The appeal must be submitted within one week of the situation precipitating the need for an appeal.

1. Submit the Appeal in writing to the course instructor. Instructor will make recommendations and give form to Dean of Nursing for final approval or denial. Official Appeal forms are available in the nursing office. **E-mail appeals will NOT be considered if not on official form.**

2. A formal written Appeal must include the following:
   - Student Name and Phone Number
   - A brief, factual report of what the student is Appealing
   - Attach any accompanying documentation to support the Appeal
   - Identify any activities on the part of the student that would support the Appeal
   - Sign and date the Appeal

3. The appeal must be submitted within one week of the situation precipitating the need for an appeal.

4. The Dean of Nursing will review the concern. The student may be contacted to meet with the Dean and Faculty Committee to clarify questions relating to the concern. The outcome decision will be communicated to the student in writing within two (2) days of the decision. The decision of the Appeal is final. No further nursing program appeal will be allowed.

**The student is solely responsible for his/her personal college matters and academic progress. The Data Privacy Act preludes the college from discussing concerns with any third party.**

## III-M. Appeal for Exception to Nursing Program Policy Form

(Must be completed within one week.) (Student signature must be on form.)

**Student Name _____ Date: _____**
**Email Address: _____**

**Course/Policy to which exception is being sought: (Include Course Number, Name and section or Policy of Program as stated in the Program Policy Manual or Course Syllabi)**

_____
_____
_____
_____

**Detailed Explanation of Circumstances that Support the Appeal.**
**Attach/include any appropriate accompanying documentation to support the appeal.**

_____
_____
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**Faculty recommendation.**

_____
_____
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_____

**Faculty signature: _____ Date: _____**

### Decision:

**Appeal Accepted _____ Appeal Denied _____**

**Student informed of Decision: In office _____ Via Phone _____ Via email _____ Date:**

**Copy of Appeal Given to Student: In office _____ Via Mail _____ Via Email_____Date:**

**Dean of Nursing _____ Student_____**

# III-N. COMMUNICATION PROCEDURE

1. CampusConnect will be the main communication center for nursing students, nursing faculty and nursing administration.
    a. **Students should check their MSB e-mail daily.**
    b. Faculty will solely use the student's school e-mail address to communicate via e-mail.
    c. Home or work e-mail addresses will NOT be used.
    d. Students are responsible for information transmitted to them via e-mail from Globe faculty, nursing administrators and the Program Project Coordinator.
    e. Students are encouraged to check the Nursing Communication Class on CampusConnect regularly throughout the quarter.

2. E-mail messages should follow the guidelines for professional communication.
    a. Respectful and courteous.
    b. Communication appropriate to e-mail communication.
    c. Utilize correct grammar and spelling
    d. Be respectful of the time frame being sent, especially if the student or faculty expect an answer. Faculty may be expected to respond to e-mail communication within normal working hours and/or as communicated in course syllabi.
    e. Disrespectful e-mail communication will be considered a violation of the Code of Conduct and will be subject to conditions as specified by the nursing program and college policy.

3. When possible, direct communication with faculty, nursing administration or the Program Project Coordinator should be via verbal communication when on campus.

4. Use of cell phone should follow the guidelines for professional communication.
    a. Texting is not the preferred form of communication between instructors and students, and is discouraged.
    b. Be respectful of the time frame in placing a call. Faculty may be expected to respond within normal working hours and/or as communicated in course syllabi.

5. Options to address questions regarding course content or progress within a course:
    a. Utilize faculty office hours. Faculty office hours are included in the course addendum each quarter.
    b. Utilize MSB email communication.
    c. Make an individual appointment with instructor.

6. Notices of a non-confidential nature will be placed in the student's mailbox in the nursing office.

7. Beginning fall 2012, each student will be assigned a nursing faculty advisor. Students should meet with their advisor each quarter as needed for individual concerns.

# III-O. SOCIAL MEDIA POLICIES

"Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals" (NCSBN White Paper: A Nurses Guide to the Use of Social Media, 2012, p. 1).

"The very nature of this medium, however, can pose a risk as it offers instantaneous posting opportunities that allow little time for reflective thought" (NCSBN "A Nurse's Guide to the Use of Social Media" pamphlet, 2012, p. 3).

The MSB nursing program adheres to the NCSBN Social Media Guidelines https://www.ncsbn.org/2930.htm

The nursing program has established clear policies about appropriate use of social media, both in the classroom and at clinical sites:

- Students are strictly prohibited from obtaining, sharing, posting, transmitting or otherwise distributing by way of any electronic media or device any patient-related image or information.
- Students should not have online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.
- Student must not make, share, post, or electronically transmit disparaging remarks about patients, families, student peers, faculty, or facility staff.
- Students must not use social media to share confidential information regarding course content that is related to test-taking, exams, skills testing, or simulation experiences.
- Students must immediately report any identified breach of confidentiality or privacy to clinical instructor.

All reported breaches will be fully investigated by faculty, reported to the Dean of Nursing, and if warranted may result in meeting with the Progression Committee, including the Dean of Students.

# III-P. ELECTRONIC DEVICES POLICIES

## 1. POLICIES ON ELECTRONIC DEVICES ON CLINICAL

- Student cell phone use or any other electronic device that has camera and/or text functions during clinical time is prohibited.
- Students must not bring these devices to the unit – they are to be left in the car or at home.
- Consequences for violation:
  - ***HIPPA violation:***
    - sent home
    - loss of Professional Accountability Points
    - must meet with Progression Committee to determine further action
      - potential failure of course with performance contract for remainder of program, or
      - potential exit from the program
  - ***First offense (non-HIPPA violation):***
    - sent home
    - required make-up
    - performance contract in effect for next 2 subsequent clinical courses
    - loss of Professional Accountability Points
  - ***Second offense (non-HIPPA violation):***
    - sent home
    - loss of Professional Accountability Points
    - must meet with Progression Committee to determine further action
      - potential failure of course with performance contract for remainder of program, or
      - potential exit from the program

## 2. POLICIES ON ELECTRONIC DEVICES IN CLASSROOM

Students are expected to come to class each week prepared to fully participate in and contribute to discussions and activities in a manner respectful to classmates and instructor. We recognize that an electronic device is required and must be brought to class charged and ready for use. However, the following rules apply to **all electronics**:

- The use of any electronic devices is prohibited during class unless the instructor gives explicit permission.
- Cell phones and other electronic devices must be turned off.
- Violation of this policy during any testing will result in a final grade of zero for the test and may require additional investigation related to Code of Conduct.

Inappropriate use of electronic devices will result in loss of Professional Accountability Points, and/or student may be required to leave the classroom.

# III-Q. STUDENT RECORDS

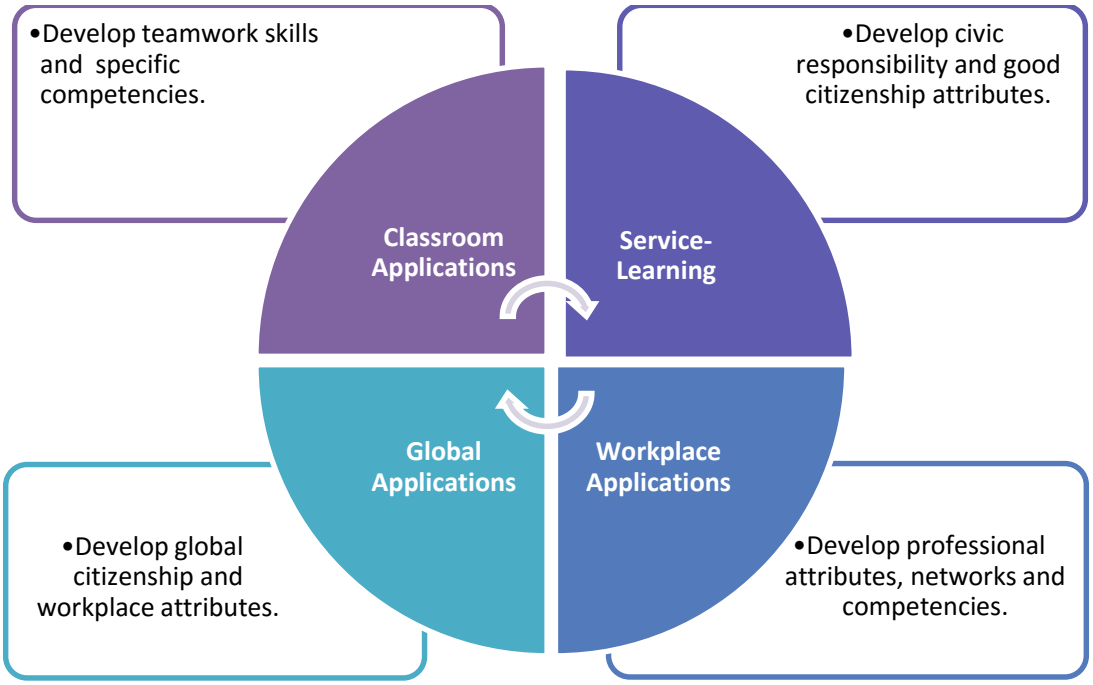
**DATA MAINTAINED IN NURSING STUDENT RECORDS**
**Students are Responsible to Supply to the Nursing Office Current Information Regarding CPR, Background Checks, Mantoux /Chest X-ray on an Annual Basis**

Nursing Student records contain confidential information listed below:

1. Immunization documentation and health evaluation, TB test must be updated annually or proof of current negative chest x-ray supplied
2. Annual criminal background check supporting clearance to provide care without restriction
3. Signed *BSN Nursing Program Confidentiality Statement / Release of Information* form
4. Student letters regarding performance, conferences, warnings, probation, progression paperwork, performance contracts, re-entry data and disciplinary records
5. Signed Nursing Program Policy Manual *Signature* form
6. Current CPR certification documentation: HealthCare Provider or equivalency
7. Signed *Release of Health Records* form
8. HIPPA Compliance Documentation

# III-R. APPLIED LEARNING

Applied learning is the "umbrella" term that defines any hands-on learning in the program and college. Service-Learning is a component of Applied Learning.




## An Introduction to Service-Learning

***What is service-learning?***

Service-learning combines meaningful community service opportunities with course learning objectives to enrich our student's academic experience.

This is accomplished by combining service tasks with structured opportunities that link the task to self-reflection, self-discovery, and the acquisition and comprehension of values, skills, and knowledge content. The service task may be completed outside class time based on community partner's needs.

***Why is service-learning incorporated into Globe University?***

- To create a heightened sense of rapport, respect, and resources available at multiple levels: classroom, campus, and public community
- To provide real service to the community and meet community needs
- To extend our classroom and provide more "hands-on" learning

    - To allow our students the visibility and opportunity to network with area nonprofits, businesses, and area schools
- To apply learned knowledge directly to the real world via service-learning activities

***What service-learning is <u>not</u>:***

- An episodic volunteer program
- An add-on to an existing college curriculum
- Logging a set number of community service hours in order to graduate
- Compensatory service assigned as a form of punishment by school administrators
- One-sided: benefiting only students or only the community

***Types of service:***

- **Direct-** Student interacts with agency face-to-face
- **Indirect Service-** Service benefits larger community or environment as a whole
    - **Advocacy-** Create awareness of social/environmental issue for public interest or to raise public concern
- **Research-** Students find, gather, and report, on information in public interest.

Adapted from the NSLC www.servicelearning.org

Nursing courses that incorporate Applied Learning:

- RN 154 Integrative Holistic Care
- RN 405 Leadership and Management in Nursing
- RN 408 Community Health Nursing

Refer to syllabi and addendum for further details and requirements for student completion of applied learning and service-learning activities within each course.

# III-S. REFERENCES

American Association of Colleges of Nursing. (2008). *Essentials of baccalaureate education.* Retrieved from http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf

American Nurses Association. (2001). *Code of ethics for nurses.* Retrieved from http://www.nursingworld.org/codeofethics

National Council of State Boards of Nursing. (2011, August). *White paper: A nurses's guide to the use of social media.* Retrieved from https://www.ncsbn.org/Social_Media.pdf

National Council of State Boards of Nursing. (2011, November). *A nurse's guide to the use of social media [pamphlet].* Retrieved from https://www.ncsbn.org/NCSBN_SocialMedia.pdf

Schmidt, L.A. (2009). Making sure: Registered nurses watching over their patients. Retrieved from http://www.stti.iupui.edu/pp07/vancouver09/41768.Schmidt,%20Lee-M%2005.pdf

**APPPENDIX**

**Globe University Bachelor of Science in Nursing**

# PINNING CEREMONY GUIDELINES & RESOURCES

**What is a Pinning Ceremony?**

- An intimate celebration and reception for family and friends held in addition to the commencement ceremony. Each student walks across the stage and receives their BSN pin from someone special to them while a optional thank you message, written by the student, is read.
- At the end of the ceremony, graduates stand as a class and recite the chosen nursing pledge. Students have expressed that this additional celebration is a meaningful and symbolic way to recognize their entry into their professional nursing career.
- The ceremony is usually 1 – 1.5 hours in length.
- The ceremony is student-organized and each class is responsible for planning, coordinating, and funding their ceremony with input and direction from the faculty. The program and speakers are selected by a student committee selected to represent their class.

The nursing pin is unique to each school, but the tradition is traced back to the Crusades of the 12th century *(see article included in this packet).* The modern ceremony dates back to the 1860s when Florence Nightingale was awarded the Red Cross of St. George and in turn presented a pin to nursing graduates. By 1916, the practice of pinning new nursing graduates was standard throughout the United States.

# TIMELINE FOR PLANNING THE PINNING CEREMONY

* If the graduating nursing students feel that these time tables are too late for planning, an earlier committee may be formed after direction from, and meeting with, the Dean of Nursing for approval to begin an earlier process.

**QUARTER 9:**
The Student Rep will distribute the Pinning Ceremony Guidelines and Packet to each member of your graduating class, either paper copies or electronically.

- *The Student Rep is not automatically in charge of Pinning; in fact, the Rep may or may not choose to even be on the Pinning Committee.*

A **minimum of three** student volunteers will be identified by their peers or self selection to attend and help at the Pinning Ceremony of the current graduating class. *(These students will then form the core of the Pinning Committee.)*
A formal Pinning Committee can be formed at this time. The Dean of Nursing needs to be invited to all meetings. The Dean may not be able to attend each meeting, but they should be given meeting notes as well. In addition, notes of all meetings must be kept and shared with the class on an open/inclusive forum such as blackboard.

- A challenge at this point is that your student group is spread out among many different courses, so it's difficult to have group discussion.
- A recommendation: Begin planning meetings and group discussion in Quarter 10 when all of your class takes Community Health together.

**QUARTER 10:**
A formal Pinning Committee **must** be formed by this time and a Pinning Committee Chairperson will be elected by consensus of the class.
Meetings to plan and coordinate the pinning ceremony are ongoing at this time. The Dean of Nursing needs to be invited to all meetings.

- *The Pinning Committee needs to keep meeting minutes and share with the class.*
- *The Dean may not be able to attend each meeting, but they should be given meeting notes as well.*

**QUARTER 11:**
Meetings to plan and coordinate the pinning ceremony are ongoing at this time. The Dean of Nursing needs to be invited to all meetings.

- *The Pinning Committee needs to keep meeting minutes and share with the class.*
- *The Dean may not be able to attend each meeting, but they should be given meeting notes as well.*

**QUARTER 12:**
**The Pinning Committee** will carry out its plans for the ceremony, and provide a count of students who want pins to **the Dean of Nursing and the Nursing Project Coordinator**. Our campus will purchase the pins for the students. Note that the Committee will be responsible for inviting Globe/MSB leadership to this event: The Richfield Campus Director and Deans, the Globe/MSB Provost, and the Myhres.

# TOP 10 DECISIONS TO MAKE FOR PINNING

**1. Choose a time for the ceremony.** ***Pinning is held on the same date as commencement.***
*The time must be agreed upon by all stakeholders. The committee must consult with faculty and conduct a vote with their class before a decision is made.*

**2. Choose a location.**
*We can provide one of the following locations for free: (a) You can hold the Pinning Ceremony several hours before commencement at the same site where the commencement will be held, or (b) You can reserve a large second floor room at Globe University corporate headquarters in Woodbury, MN. Students may rent a different location. Note: June graduating classes should try to reserve a location early due to wedding season. A list of cost effective locations in the area is provided with this planning guide.*

**3. Choose what refreshments you wish to have, if any.**
*In recent years graduating classes have opted for additional food and beverage at the ceremony such as light hors d'oeuvres though this is not a requirement. There is a cake and punch reception held following the graduation ceremony as well.*

**4. The class must vote to approve the overall cost of the event.**
*In the past, some graduating classes have chosen to pay for a pinning site different from the one used for commencement. There are concerns from faculty and students that costs be kept reasonable.* ***The Pinning Committee is required to get the overall cost of the event approved in a vote from the class****. In the past, some classes have conducted fundraising efforts to cover these costs. Please note that* ***any fundraising*** *by nursing students needs to be approved by the Dean of Nursing.*

**5. Choose a student speaker.**
*Optional: sometimes, a class has chosen two student speakers. One to explain the history of the pinning tradition, and one to speak for the class about its journey.*

**6 . Choose a faculty speaker.**
*In addition, the Dean always speaks at Pinning, usually during the Welcome.*

**7. Choose one (or more) faculty to read student names to call them to stage to be pinned.**

**8. (Optional:) Choose one (or more) faculty to read student's written comments while the student is being pinned.**
*The process of walking to the stage and having the pin secured on the student's clothing always takes time. During this time, a brief statement written by the student is read – thanking the pinner, expressing what the journey into nursing has meant, etc. In our experience, this has never extended the ceremony, but simply added another dimension during what would otherwise be simply a long silence. (The committee will set a time and/or word limit to help keep statements brief.)*

**9. (Optional:) Choose if you would like to end the ceremony with a *Blessing of the Hands (see program suggestions)*, which is read aloud to the class.**

**10. Choose a pledge (see *program suggestions and sample survey*)**

# Program Suggestions

## ***Blessing of the Hands***

May the work of your hands bring healing to all the people you touch.
May you be blessed with…

- a spirit of gentleness and a heart that is tender.
- a spirit of strength shining within you.
- a spirit of compassion and sincere caring.
- a spirit of courage, daring to be who you are.
- a spirit of openness, understanding & respect.

May the work of your hands bring healing to all the people you touch.

***Variations: (a) Can be read entirely by one person, such as the dean. (b) A leader could read the first, second, and last lines, then assign each bulleted line to a separate individual. (c) A group of people could read it all in unison.***

## ***Nursing Pledge Variations (see nursing survey below)***

**FIND OR CREATE A DIFFERENT VARIATION OF THE PLEDGE.**

***Optional: Candles may be used. (a) Students can hold lit candles during the recitation of the pledge. (b) At the end of the ceremony, students can carry lit candles and leave the room as a group, symbolizing carrying the Nightingale lamp out into the world.***

# Sample Class Survey on Pinning Ceremony

Congratulations 3rd Year Nursing Seniors for making it this far!!! In a few months, you will be saying farewell to the end of this chapter in your life as a nursing student and beginning a new one as a registered nurse. The Pinning Committee along with faculty members is working in collaboration to make your pinning ceremony a memorable event.

Please note on your calendars that graduation will be on held on _____.
The ceremony will be held at _____.
More information on exact time will be announced later on.

Please complete the following survey questions below and
return to _____ by _____.
It can be placed in nursing mailbox as well. Thank you!

**1.** During the pinning ceremony, each graduate will have the opportunity to invite a family member, friend, or staff member to pin the nursing pin onto the graduate. Please state who you would like to pin you during the ceremony:

Student name: _____

Person that will pin you: _____

Relationship: _____

**2.** How many people are you planning to invite? _____

**3.** Please vote on two faculty members who you would like to announce the names of graduates during the pinning ceremony:

a. _____

b. _____

**4.** A Nursing Pledge is recited at the end of the pinning ceremony signifying the passage of student nurses to practicing nurses. There are many variations of the pledge. Please vote for your favorite.

**A. The Florence Nightingale Pledge**

"I solemnly pledge myself before God and in the presence of this assembly to faithfully practice my profession of nursing. I will do all in my power to make and maintain the highest standards and practices of my profession. I will hold in confidence all personal matters committed to my keeping in the practice of my calling. I will assist the physician in his work and will devote myself to the welfare of my patients, my family, and my community. I will endeavor to fulfill my rights and privileges as a good citizen and take my share of responsibility in promoting the health and welfare of the community. I will constantly endeavor to increase my knowledge and skills in nursing and to use them wisely. I will zealously seek to nurse those who are ill wherever they may be and whenever they are in need. I will be active in assisting others in

safeguarding and promoting the health and happiness of mankind."

**B. The UTA Son Professional Nursing Pledge**

"With full knowledge of the responsibilities I am undertaking, I pledge to care for my patients with all of the knowledge, skills, and understanding that I possess, without regard to race, color, creed, politics, or social status. I will spare no effort to conserve meaningful life, to alleviate suffering, and to promote health. I will refrain from any action which might be harmful to the quality of life or health of those I care for. I will respect, at all times, the dignity and religious beliefs of patients under my care, and hold in professional confidence all the personal information entrusted to me. I will endeavor to keep my professional knowledge and skills at the highest level and give my support and cooperation to all members of the health care team. With full awareness of my qualifications and limitations, I will do my utmost to maximize the potential of the nursing profession and to uphold and advance its standards".

**C. OTHER:**

**5.** Is there anything special that you would like to incorporate into the ceremony?

**6.** If you would like to help with the following tasks for the pinning ceremony, please place your name or an X by the task.

( ) Programs

( ) Decorations

( ) Set-up/take down

## Cost Effective Rental Facilities in the Area

**Bloomington:**
Creekside Community Center
9801 Penn Ave. S
Bloomington, MN 55431
PH: 952-563-4944
E-mail: humanservices@ci.bloomington.mn.us

Bloomington Center for the Arts
1800 W. Old Shakopee Road
Bloomington, MN 55431
Jim Urie, Center for the Arts Manager
PH: 952-563-8881
E-mail: jurie@ci.bloomington.mn.us

Normandale Lake Bandshell rental (for June Pinning events)
Bloomington Parks and Recreation Division
1800 W. Old Shakopee Road, Bloomington, MN 55431-3027
PH: 952-563-8877

**Edina:**
Centennial Lakes Park (Indoor and Outdoor Facilities)
7499 France Ave. S., Edina, MN 55435
PH: 952-833-9580
email: edinamail@ci.edina.mn.us
Laura Knollmaier, Assistant Park Manager

Braemar Golf Course Clubhouse
6364 John Harris Drive, Edina, MN 55439
PH:952-903-5750
email: BraemarGolf@ci.edina.mn.us
Amy Smith, Banquet Manager

Southdale Public Library
7001 York Ave. S.
Edina, MN 55435
PH: 612.543.5900
Online Reservation System: http://www.hclib.org/pub/info/meetingrooms/

**Richfield:**
Richfield Community Center
7000 Nicollet Ave. S.

Richfield, MN 55423
PH: 612-861-9395
email contact: jevans@cityofrichfield.org

# *The Nursing Pin: Symbol of 1,000 Years of Service*

**by Mary W. Rode**

**The nursing pin is a 1,000-year old symbol of service to others. The earliest ancestor of the pin dates back to the Maltese Cross, adopted by crusaders and worn on their habits as a symbol of service to Christianity. Over the centuries, variations of the crusader's symbol were gradually modified and became family coats of arms, often symbolizing service to a ruler. By the Renaissance, guilds had adopted coats of arms symbolizing masterful service to the community. The most recent ancestor of the pin is the hospital badge of 100 years ago. It was given by the hospital school of nursing to the students to identify them as nurses who were educated to serve the health needs of society. This symbol of service involves many professional rights and responsibilities.**

Every year, graduating student nurses across the nation participate in pinning ceremonies. It is an occasion of great significance for many reasons. It means they have completed their educational requirements and can sit for the state licensure examination. It means farewell to friends with whom they have lived and worked for several years. When the dean of their school attaches the school pin onto the graduate's lapel, cameras flash, tears flow, applause is heard. Sometimes hoots and cheers echo through the halls.

Although pinning is a meaningful experience for most graduate nurses, not all them view pinning as worthwhile. Leininger (1976) observed that nursing majors educated in institutions of higher learning are strange and different from students in other majors because they spend great energy on a pinning ceremony as well as the usual commencement ceremony. Whether nurses value pinning or are indifferent to it, few are acquainted with the history of the pin.

*Mary W. Rode is an Associate Professor of Nursing, University of Evansville, Evansville, IN.*

Today the nursing pin communicates the wearer's earned right to practice nursing and also the source of his/her education. The pin and its precursors have been nursing's tangible symbol of this service to others for nearly one thousand years. One can trace the pin back to the Maltese Cross, family and guild coats of arms, and most recently school badges.

### The Maltese Cross

The earliest ancestor of the nursing pin dates back to the Crusades. Crusading knights occupied the Holy Land and were involved in a wide range of military duties ranging from pitched battles to skirmishes. By controlling particular areas, Christians were able to trek to the Holy Land on

religious pilgrimages and to trade commercially. Early in the Crusades, it became clear that the Christian travelers and wounded knights needed protection, adequate food and shelter, and relief from sickness and suffering. In response to these needs, the military nursing orders developed (Nutting & Dock, 1935; Iveson-Iveson, 1982).

The first and most famous of several orders of military hospitallers was the order of St. John of Jerusalem. In the beginning these male nurses were not fighting knights; their role was to nurse the pilgrims and the wounded. Within a few years, however, it became apparent that the nursing knights often had to fight to defend the hospital. These warrior monks then had two distinct roles — a nursing one and a military one.

To accommodate their military duties, the hospitaller knights wore armor. Because of their religious duties they also wore habits with cowls or tunics over the armor. On their habits they wore a white linen eight-pointed Maltese Cross to identify the wearer as a member of a particular order. Each order attached the cross in a slightly different place on the habit, but it was most often centered on the chest. This white Maltese Cross, over the heart, symbolized purity of heart. The eight points stood for the beatitudes that the knights were bound to obey. Hence, the cross, earliest forerunner of the nursing pin, represented service to Christ and the values of Christianity (Donahue, 1985; Iveson-Iveson, 1982; Nutting & Dock, 1935).

*By the 16th century, the family insignia — or coat of arms — adorned many family possessions. It was a symbol of privilege earned long ago for service in the Christian wars. A man without a family coat of arms during this period could earn one and gain entrance into the privileged class by showing loyal service to the ruler.*

The hospitaller knights were famous for their good works, chivalry, and excellent hospital management. Young men all over Europe wanted to join the orders, especially the Knights of St. John. Membership in that order alone reached 30,000 (Nutting & Dock, 1935). It was considered an honor to be a hospitaller knight and to have the privilege of wearing the Maltese Cross of Service.

**Family Coat of Arms**

The habits or tunics, which covered the armor of the hospitaller knights, were also used by military knights. The tunics of military knights were decorated with an embroidered insignia that matched the warrior's shield. As the Crusades ended and the centuries passed, the original tunic insignia, whether hospitaller or military, was retained by the knights' descendants as a personal genealogy. By the 16th century, this old family insignia — or coat of arms adorned many family possessions. It was a symbol of privilege earned long ago for service in the Christian wars. A man without a family coat of arms during this period could earn one and gain entrance into the privileged class by showing loyal service to the ruler (Ellis & Hartley, 1984).

There are two important words to examine when considering the symbolism of the coat of arms. The first is service. During the early crusades, there was total service to Christian values. By the 16th century there was gradual movement away from the church and toward secular affairs, hence service to the king or ruler was valued and rewarded. The second word of importance is privilege. A privilege is an earned right, and is usually endowed by a person or organization of some legitimate power. Having a family coat of arms meant one was privileged to serve the ruler, and service was considered an honor.

**Guild Coat of Arms**

The privilege of wearing a coat of arms was also extended to members of schools and guilds during the later Middle Ages and the Renaissance (Ellis & Hartley, 1984). Each field of endeavor had a guild, which promoted the interest of members. The guild was also a public service in that it protected the public from frauds by controlling membership. To be admitted to membership, the artisan or worker had to show mastery in the field and high standards of workmanship. Long periods of preparation were required to ensure competence, usually by way of apprenticeships rather than by formal education (Donahue, 1985). Each guild had a coat of arms fashioned with its own exclusive symbolic design. It was carried or worn by members for purposes of status and identification (Ellis & Hartley, 1984). Although there were no guilds for nurses, there were guilds for midwives (Dolan, 1958).

The guild coat of arms meant high quality service to the public. It is important to remember that the right and privilege to serve the public had to be earned through some level of mastery in the field. Earning the right to serve through training was quite different from gaining the privilege by showing loyalty to a ruler, as happened in the 16th century.

## Hospital Badges

By the late 19th century, English hospitals began "training schools" for nurses as a result of Florence Nightingale's influence. These schools awarded gold and silver medals to recognize outstanding nurses. Wolverhampton Royal Hospital was among the first English schools to alter this custom by awarding all Wolverhampton graduates a badge to wear on their uniforms. Other schools followed, including the Nightingale School of Nursing at St. Thomas's Hospital in London. A badge with a Maltese Cross, the original symbol of service, was designed for the Nightingale School of Nursing. By 1916, the custom was well established in England and in America (Ellis & Hartley, 1986; Dopson, 1982).

School badges identified nurses as educated women who served the health needs of society, held Christian values, and were loyal to country. The nurses from Nightingale-type schools were a dramatic contrast to the 19th century nurses described by Dickens. Nurses in Dickens's novels were characterized as gamblers and alcoholics and were disagreeable interpersonally (Donahue, 1985; Ellis & Hartley, 1984; Nutting & Dock, 1935). The new educated nurses, in contrast, were very much respected and in great demand. They were the best for those times, and so the badge came to symbolize excellent nursing. Furthermore, the hospital that awarded badges to these nurses was seen by the public as an excellent care provider.

Owing to the favorable public response, eventually each school of nursing designed and endowed its graduates with a badge or pin embossed with that school's identifying symbol. Many of the early schools adopted the area or ruler coat of arms as their badge's logo. For example, the Prince of Wales Hospital adopted the Prince's coat of arms, which included the Dove of Peace and the Cross of Mercy (Dopson, 1982). The nursing pin's most recent ancestor, then, is the hospital badge, which evolved from the guild coat of arms and the crusader's Maltese Cross. The actual designs of pins today may include a cross, but whatever the image on the pin, the pin is a source of pride for nurses. It symbolizes nearly 1000 years of service to others.

*When one accepts the nursing pin, which symbolizes the right to practice nursing, one also accepts many responsibilities. The nursing pin communicates to the consumer of nursing services that the wearer is a competent nurse: educated, knowledgeable, and possessing professional attributes as she/he services the health needs of the public.*

## Rights and Responsibilities

Service, which is important to the social welfare, has long been considered a major characteristic of the professions (Crowder, 1985). The concept of service includes rights and responsibilities. The right to serve people must be earned by gaining appropriate knowledge. The right is endowed on people by the school and the legal system. Hence, today, nurses must earn the right and prove their worthiness to serve others — both to the school (instead of the guild or religious order) and to the state (instead of the ruler).

When one accepts the nursing pin, which symbolizes the right to practice nursing, one also accepts many responsibilities. The main responsibility, however, is a promise to the public to offer safe, reasonable care. To do this, nurses must not only have adequate knowledge at that moment, but they must keep their knowledge current. The nursing pin communicates to the consumer of nursing services that the wearer is a competent nurse: educated, knowledgeable, and possessing professional attributes as she/he services the health needs of the public.

## References

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Ellis, J., & Hartley, C. (1984). *Nursing in Today's World: Challenges, Issues and Trends* (2nd ed.). Philadelphia: Lippincott.

Iveson-Iveson, J. (1982). Knight nurse. *Nursing Mirror*, 154(15)28-30.

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# SIGNATURE PAGE

I, _____, have received a copy of the Globe University BSN Nursing Policy Manual dated 2012. I understand that I am responsible for reading and understanding the content in this manual.

_____
Student Signature

_____
Date

# ACADEMIC INFORMATION

## ADD/DROP PERIOD

The first five business days of each course session (and the first business day of the second week of the quarter for individual classes that meet for the first time on Saturday of the first week of the course) are designated as the "add/drop period" for schedule changes involving individual courses. By the end of the five-day period, each individual's schedule will be in place for the remainder of the course length. Individual courses dropped during this period will not appear on a student's transcript and no tuition will be charged. Students who attend classes within the add/drop period and completely withdraw from school during the first week will be charged for the portion of the courses attended and receive a grade of W. Courses that a student has attended and dropped after the add/drop period will appear on the student's transcript. Tuition and applicable fees for the course will be charged to the student's account.

## ATTENDANCE REQUIREMENTS

Students are expected to be present and on time for all residential class meetings. Globe University/Minnesota School of Business does not distinguish types of absence. Instead, attendance is monitored for all class sessions and is recorded as actual time attended. Any time missed from a scheduled class is considered time absent. The student is responsible for notifying the academic services department of any absences. The student is also responsible for communicating with his/her instructor when absent from part or all of a class to determine missed assignments, due dates, and his/her eligibility for submitting missed class work.

A student registered for an online course is expected to log into the course within the first 72 hours (three days) of the quarter and log in and participate in the course at least once per week throughout the quarter. Online courses require a high level of interaction and participation in the course environment. It is highly recommended that students registered in online courses log in to each course at least three times per week each week of the quarter.

Ten consecutive business days of absences from one or more courses will result in the administrative withdrawal from such course(s) and may lead to discontinuation of enrollment at GU/MSB. This may result in failure of the course(s) and may lead to discontinuation of enrollment at GU/MSB. A student not in attendance by the end of the add/drop period may be dropped from all courses and withdrawn from school.

Regular and punctual attendance is a very important part of training for employment. Undergraduate students who achieves perfect attendance in a given quarter will receive a 25% discount off of one merchandise item purchased the quarter following the student's achievement. Perfect attendance for residential courses is defined as being present for the full length of every class period for which the student is registered for the entire length of the quarter. Perfect attendance for online courses is defined as meeting the discussion board deadlines and expectations each week (Monday through Sunday), outlined in the Online Class Expectations of every online course. Perfect attendance for hybrid courses is defined as participating once a week in the online component of the course and present for the full length of every residential class session. The perfect attendance savings will only be granted to students who are actively taking classes in the quarter immediately following the earning of the perfect attendance award. Students who take a quarter off will forego the perfect attendance savings.

## AUDIT POLICY

An audited course is one in which a student who is enrolled in a program and is actively taking classes is allowed to attend class and participate. The student is expected to fulfill the audit agreement as determined by the dean of education/students and is encouraged to participate fully in all aspects of the class. A student who wishes to audit a course must obtain permission from the dean of education/students and register for the course. A student may not change a course registration from credit to audit after the add/drop period. A student auditing a course will be responsible for the cost of books and/or supplies and fees associated with the course. Any graduate of GU/MSB may return and audit any previously completed course as a refresher (please see Refresher Courses in the General Information section of this catalog).

## CONDUCT

A student must establish and maintain a record of good standing throughout the student's program. Good standing includes satisfactory attendance and academic performance as well as courteous personal behavior. Any conduct that disrupts the learning environment may result in permanent dismissal. The institution reserves the right to dismiss a student when personal conduct, attendance, or academic progress is considered to be unsatisfactory. The student will only be readmitted to school with the approval of the campus director and dean of education/students. Globe University/Minnesota School of Business is committed to providing an open, diverse, and insightful learning environment in all of its residential and online courses. Communication in the online course environment should at all times be professional, courteous, and respectful of the diversity of the community.

### Academic Dishonesty

Academic dishonesty includes cheating on tests or assignments, turning in work completed by others, turning in the same work or portions of the same work for different courses without the prior approval of the instructors, providing false or misleading information to faculty or staff members, unauthorized collaboration on any academic work that is intended to be completed individually, or plagiarizing. All work submitted must be in the student's own words and must cite the source of the idea where applicable. Students who act dishonestly may receive a zero or receive a failing grade for the course. Repeated or serious violations may result in termination of educational privileges. If a student wishes to appeal disciplinary actions such as these, he or she must follow the grievance policy found in this catalog.

### Academic Freedom

Students are entitled to freedom in the classroom in discussing their subject, but should be careful not to introduce controversial matters that have no relation to the subject.

### Consequences of fair use law violations

Illegal duplication of computer software may constitute criminal copyright infringement, which is punishable by a fine of up to $250,000 and imprisonment for up to five years. Federal civil penalties allow the recovery of actual damages based upon the number of copies produced or statutory damages ranging up to $100,000 for willful copyright infringement. If you know of any illegal copying of software within GU/MSB, please contact the dean of students/education immediately.

### What are the details of fair use at GU/MSB?

GU/MSB has developed standards to govern the use of computer equipment and networks. In general, it asks that you obey the law and be considerate of others. Specifically, you may not:

- Enter, without authorization, into another user's network account or file space to use, read, transfer or change contents therein for any purpose[1]
- Use another individual's network account or password
- Grant another individual access to your network account[2]
- Use GU/MSB computing facilities to interfere with the work of other students
- Use GU/MSB computing facilities to send obscene, abusive, derogatory or harassing messages
- Use GU/MSB computing facilities to display, transmit, distribute or make available information that expresses or implies discrimination or an intention to discriminate
- Use GU/MSB computing facilities to interfere with the normal operation of the school's computing facilities, including such things as flooding the network with messages, sending commercial solicitations, and sending chain or pyramid letters
- Use GU/MSB computing facilities for personal profit or commercial gain
- Use GU/MSB computing facilities to gain unauthorized access to any computing facilities of GU/MSB or any other commercial, non-commercial or government entity
- Use GU/MSB computing facilities to interfere with the operation of any other commercial entity
- Use GU/MSB computing facilities to display obscene or otherwise offensive images
- Place any software or data that is illegal for any reason anywhere on GU/MSB computing facilities
- Use GU/MSB computing facilities in any way that violates the intellectual property rights of GU/MSB or of any other commercial or non-commercial entity. This provision specifically prohibits the use of any unlicensed software on GU/MSB computing facilities.
- Use or develop programs such as viruses and Trojan horses that harass other users, modify the system or account or cause damage to system resources; or knowing transmission of any such destructive program

[1] An exception to this rule is that IT personnel may enter another user's account for the purpose of necessary maintenance or if directed to do so by executive management for investigation of suspected violations of school policy and/or criminal wrongdoing. In the latter case, a record of any such access will be kept.

[2] You may grant IT personnel access to your account for the purpose of repair of, or maintenance to, your system. You should change your password at the completion of these activities.

See also Copyright and Intellectual Property, below.

## CONDUCT

The business community demands professional behavior at all times. GU/MSB follows good business practice by requiring all students to show respect for one another and for GU/MSB employees. Students are expected to be respectful of instructors and classmates. Examples of disrespectful behavior include talking while the instructor is teaching, tardiness, answering cell phone calls during class, leaving class early, viewing inappropriate sites on any of the school's computers or using verbal, written or e-mail communication that is of a slanderous, harassing, threatening, or inappropriate nature regarding other students, faculty, administration or staff of the college.

Failure to behave in a mature, businesslike manner will result in a conference with the instructor and/or the dean of students/education. Continued disruptive behavior may lead to dismissal.

## STUDENT COURSE LOAD POLICY

In order to complete a degree in the standard time frame (one and one-half to two years for an associate degree and three years for a bachelor's degree), a student must complete an average of 15 credits per quarter, based on attending four quarters a year. In order to complete a degree in the standard time frame for a masters; program (one and a half years), and for a doctoral program (two years), a student must complete an average of 9 to 10 credits per quarter. That course load may include credits earned in the following ways: at the student's home campus, online, through attendance at a non-home campus or school for which a consortium agreement exists and through externship/internship hours.

Globe University/Minnesota School of Business provides a master class schedule that lists all course offerings at all campuses for the specified quarter. The course catalog will note programs that require students to travel to specific campuses for specialized courses or for courses that may have limited offerings. Students who choose not to follow the recommended course sequence for a program may need to take a required class at another campus, online, or through a blended delivery format.

## STUDENTS WITH DISABILITIES

The Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 guarantee students with disabling conditions equal access to educational opportunities. All students with physical or mental disabling conditions seeking academic adjustments and/or other modifications because of a disabling condition are eligible to receive academic adjustments in the educational environment and for participating in programs, services, and activities offered by Globe Education Network member schools. Academic adjustments and/or modifications include, but are not limited to, auxiliary aids, changes in the length of time permitted for the completion of degree requirements, substitution of specific courses required for the completion of degree requirements, adaptation of the manner in which specific courses are conducted, and/or modification of school policies and procedures. Globe University/Minnesota School of Business is not required to make adjustments and/or modifications that are essential to the instruction being pursued or would fundamentally alter the nature of the service, program or activity, those that represent a personal service, or those that would result in a violation of accreditation or regulatory requirements.

A student wishing to request reasonable accommodation must submit a Disclosure of Disabling Condition and Request for Academic Adjustment to the dean of education/students at the student's home campus, including acceptable documentation concerning the disability, so that reasonable accommodations can be made. Some important considerations follow:

1. Potential students requesting accommodations for the entrance assessment must complete the accommodations process prior to being granted such accommodation.
2. Accommodations are not granted on a retroactive basis. Academic work that has been submitted prior to a request cannot be resubmitted with the accommodations granted and will remain graded as originally submitted.
3. Applicants requesting accommodations must acknowledge that the school is afforded an appropriate amount of time to determine and secure reasonable accommodations. Accommodations that require the acquisition of equipment, software/hardware, or additional resources will require additional time to secure and will not be immediately available upon request.

It is the student's responsibility to self-disclose a disabling condition and to request reasonable accommodation as soon as the student determines a need or desire for such accommodation. For more information about required documentation or to request academic adjustments, please contact the dean of education/students at your home campus.

## TERMINATION BY THE INSTITUTION

The institution reserves the right to terminate the enrollment of any student who engages in the following:

- Failure to maintain passing grades
- Tardiness or absences in excess of school policy
- Failure to pay a school financial account
- Destruction of or damage to any property of the school (the student may also be held liable for repair or replacement of the damaged property)
- Unlawful or improper conduct (including academic dishonesty)
- Conduct contrary to the best interest of the school or that reflects discredit upon the school
- Behavior disruptive of normal classroom conduct

## TRANSCRIPTS

A copy of each student's transcript is available upon request by the student. This service is subject to the Family Educational Rights and Privacy Act of 1974. The school reserves the right to withhold an official transcript if the student's financial account is in arrears.

There is a processing fee of $5 for each official transcript.

Transcripts issued by Globe University/Minnesota School of Business will include the student's coursework completed at those institutions and any additional coursework completed at Broadview University, the Institute of Production and Recording, and/or Minnesota School of Cosmetology.

## U.S. DEPARTMENT OF EDUCATION PROGRAM DISCLOSURES

Information regarding program cost, graduate outcomes, and the occupations each program prepares students to enter can be accessed via links on the individual program web pages within the Globe University and Minnesota School of Business websites. The program web pages can be accessed by using the following links: Globe University programs – http://www.globeuniversity.edu/outcomes; Minnesota School of Business programs –http://www.msbcollege.edu/outcomes.

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: Agrace Hospice Care

Address: 5395 E Cheryl Parkway

Madison, WI 53711

Telephone: 608-276-4660

B. Type of facility: ☐ Hospital ☒ Nursing Home ☒ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 50 inpatient beds

D. Types of patients: Hospice, Terminal Illness

E. Administrator of facility: Lynne Myers, President & CEO

F. Director of nursing service: Pamela Edwards, Chief Clinical Officer

G. School(s) of nursing utilizing the facility: University of Wisconsin School of Nursing, Herzing, Edgewood, Madison Area Technical College

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulation equipment will be utilized at this site.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? X Yes ____ No

Comments: _____

B. Does the facility agree to cooperate in promoting the nursing school objectives? X Yes ____ No

Comments: _____

C. Are there experiences in the facility available to students to meet clinical objectives? X Yes ____ No

Comments: _____

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

_____

_____

_____

| | |
|---|---|
| Globe University<br>Nursing School | Bachelor of Science in Nursing (BSN)<br>Nursing Program(s) Utilizing Facility/Simulated Setting |
| Kendra Saal<br>Educational Administrator | Dean of Nursing<br>Title |
| Kendra Saal<br>Signature | 8/24/2016<br>Date |
| 612-455-4781<br>Telephone Number | ksaal@msbcollege.edu<br>Email Address |

THIS EDUCATIONAL TRAINING AGREEMENT is made and entered into on this 1st day of September, 2016 ("Effective Date") by and between Globe University, Inc. and Minnesota School of Business, Inc. ("Trainer") and Agrace HospiceCare, Incorporated ("Agrace").

RECITALS

A. Trainer has established educational training program(s) for its students, which is described in Exhibit A (the "Program").

B. Trainer and Trainer's students participating in the Program ("Trainees") would benefit from educational opportunities available at Agrace, and Agrace is willing to allow Trainer and Trainees to train at Agrace.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Trainer Obligations.

(a) Operation of Program. Trainer shall be solely responsible for the safe and effective operation, administration and oversight of the Program and Trainees. Program shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements. Trainer represents and warrants that Trainer and the Program shall maintain at all times during the term of this Agreement: (i) accreditation as an educational institutions; (ii) all licensures and approvals from appropriate State Agencies necessary to the applicable Program; and (iii) full and unrestricted accreditation of the Program from the accrediting organization specified in the applicable Program addendum. Trainer shall promptly notify Agrace of any change in its accreditation or licensure status

(b) Instructors. Trainer shall assign an appropriate number of qualified instructors to supervise and train Trainees ("Instructors"). Trainer represents and warrants that all Instructors are duly licensed, credentialed, certified and/or registered under the laws of the State of Wisconsin, have not been excluded from participation in any federally funded health care program, and possess the education, skills, training and other qualifications necessary to perform the Instructors' functions.

(c) Completion of Course Curriculum. Trainer represents and warrants that each Trainee, prior to training at Agrace, is adequately prepared to benefit from such assignment. A Trainee's preparedness shall be measured by: (i) academic performance indicating an ability to understand what Trainee will

observe and/or perform during the training; and (ii) appreciation of the nature and seriousness of the work Trainee will observe and /or perform. If applicable, Trainer represents and warrants that Trainees also meet the following:

(d) (d) Number of Placements. Agrace shall have sole discretion to determine its capacity to accept Trainees for clinical placement under this Agreement, whether such capacity is described in terms of the number of Trainees on-site at any one time, the number of hours of supervision that Agrace can provide over a period of time, or other such description of capacity. Agrace shall communicate such capacity to Trainer before Trainees may be assigned to Agrace.

(i) Nursing Students. If Trainees are nursing students, then Trainer represents and warrants that Trainer will maintain an average score equal to or above the national average passing rate from the National Council Licensure Examination ("NCLEX").

(ii) Physician Residents. If Trainees are resident physicians, then Trainer represents and warrants that each Trainee has a Doctor of Medicine or Doctor of Osteopathy from an institution accredited by the Liaison Committee on Medical Education or the American Osteopathic Association Commission on Osteopathic College Accreditation.

(e) Background Checks. Trainer shall perform a background check in accordance with the Wisconsin Caregiver Background Check Law, as set forth in Wisconsin Administrative Code Chapter DHS 12, on each Instructor and Trainee prior to his or her starting to train at Agrace. The background check shall include obtaining, as applicable, information from the Department of Justice, the Department of Safety and Professional Services, the Department of Health Services and from out-of-state agencies if the Trainee has lived outside of Wisconsin within the past three years. Prior to placement of the Trainee, Trainer will notify Agrace in writing of any crime of which Trainee has been convicted so that Agrace may make a determination as to whether the conviction bars the Trainee's participation in an Agrace clinical setting. Trainer hereby agrees to notify Agrace when Trainer becomes aware that any Trainee on site at Agrace is charged with or convicted of any crime or is investigated by any governmental agency. Trainer shall retain all background record checks in accordance with applicable laws and shall promptly provide such records to Agrace upon its request. Trainer shall not allow any individual to train or serve as Instructor who has been found to have engaged in improper or illegal conduct relating to the elderly, children, or vulnerable individuals, or who would otherwise be barred from providing services under Chapter DHS 12.

(f) Orientation and Compliance with Agrace Policies and Procedures. Trainer shall require its Trainees and Instructors to comply with all Agrace policies and procedures and attend all mandatory training and orientation provided by Agrace or Trainer. Prior to instructing or performing training

assignments, Trainer shall provide Instructors and Trainees with appropriate training so they are familiar with Agrace, its policies, procedures and facilities, including training regarding Agrace's policies and procedures for handling Health Information (defined below).

(g) Communicable Disease and Tuberculosis ("TB") Screening. Trainer represents and warrants that all Trainees and Instructors are free of communicable disease and have a negative TB skin test or chest x-ray, if such persons may have direct contact with Agrace patients. Trainer shall maintain records of such tests and shall promptly provide such records to Agrace upon its request. The vaccinations include Hepatitis B, Varicella, Measles, Mumps, Rubella 1 and 2, Tetanus/Diphtheria/Pertussis, and the Flu Shot.

(h) Nondiscrimination. Agrace and Trainer shall comply with all applicable state and federal law to ensure that both parties will not discriminate against any trainee, trainer, employee or applicant for admission into a Program, on the basis of race, color, age, gender, national origin, disability, sexual orientation or marital status.

(i) Coordination with Agrace. Trainer shall coordinate with Agrace in the assignment and scheduling of Trainees.

(j) Uniforms. Trainer shall require that Trainees and Instructors wear professional attire when training at Agrace along with a name badge that clearly indicates the individual's name, student status, the individual's affiliation with Trainer and any other specific information Agrace may reasonably require.

(k) Cooperation with Complaints. In the event of any complaint filed by or with respect to a Agrace patient or any investigation or inquiry initiated by any governmental agency or any litigation commenced against Agrace that may involve Trainer, Instructor or any Trainee ("Complaint"), Trainer shall fully cooperate with Agrace in an effort to respond to and resolve the Complaint in a timely and effective manner. If the Complaint relates to this Agreement, then Trainer shall, in addition to any obligations under section 2, cooperate fully with any insurance company providing protection to Agrace in connection with the Complaint. In this connection, Trainer agrees to notify Agrace promptly of any Complaints and to cooperate fully with the directions of Agrace with respect thereto.

(l) Trainee Responsibility. Trainer represents and warrants that it informs and has Trainees acknowledge in writing that Trainee's presence at Agrace is in the status of an invitee solely for the purpose of Trainee's education and participation in the Program and that there exists no employer-employee relationship or independent contractor relationship between Trainee and Agrace; and Trainee is responsible for his or her actions when performing training assignments and will follow all instructions and will use the methods and

techniques taught by Trainer. Trainee shall refrain from the improper use of alcohol or other drugs and shall not carry any firearms or other weapons while on Agrace premises. Trainee shall immediately inform Agrace and Trainer of Trainee's inability to report to Agrace as assigned.

(m) Attendance at Meetings. At the request of Agrace, Trainer, Instructors and Trainees shall attend meetings with Agrace personnel to review the operation of the Program and any specific concerns.

(n) Notification of Changes. Trainer shall immediately notify Agrace of any changes or threatened changes to the representations and warranties contained in this Agreement.

2. Insurance and Hold Harmless.

(a) Insurance. Trainer shall obtain and maintain appropriate comprehensive general liability and worker's compensation insurance in at least the minimum amounts required from time to time by applicable federal and state laws and regulations, but in no event shall general liability coverage be less than $1,000,000 per occurrence and $3,000,000 in the aggregate or such other amount agreed to by the parties. Such insurance shall cover Trainer, Instructors and Trainees. Agrace shall be identified as an additional insured. Trainer shall provide Agrace with evidence of such coverage, as may be reasonably requested by Agrace. Trainer shall instruct and obtain the consent of the insurer to provide at least thirty (30) days prior written notice to Agrace of any cancellation or non-renewal of or material change in any policy.

(b) Indemnification and Hold Harmless. Trainer shall indemnify, defend and hold harmless Agrace, its governing board, officers, employees and agents from and against any demands, claims, actions, causes of action, assessments, losses, damages, lawsuits, judgments, liabilities, costs and expenses, including, without limitation, interest, penalties and reasonable attorneys' fees, sustained or incurred by Agrace as a result of, arising out of or incidental to any breach of this Agreement or any act or omission of Trainer or any Trainee or Instructor.

(c) Indemnification and Hold Harmless. Agrace shall indemnify, defend and hold harmless Trainer, its governing board, officers, employees and agents from and against any demands, claims, actions, causes of action, assessments, losses, damages, lawsuits, judgments, liabilities, costs and expenses, including, without limitation, interest, penalties and reasonable attorneys' fees, sustained or incurred by Trainer or any Trainee or Instructor as a result of, arising out of or incidental to any breach of this Agreement or any act or omission of Agrace.

(d) Statutory Liability Protection. If Trainer is a public institution, nothing in this Agreement shall be construed to waive, deny or in any

way restrict liability coverage available to the Trainer or any Trainee or Instructor or any other agents of Trainer under section 895.46(1) of the Wisconsin Statutes. For purposes of that section, the Trainees and Instructors shall be considered agents and employees, respectively, of Trainer, and shall be considered acting within the scope of their agency or employment while participating in the Program.

3. Agrace Obligations.

(a) Access to Premises, Supplies and Equipment. Agrace shall provide Trainer, Instructor and Trainees with access to its premises and use of its supplies and equipment, as reasonably necessary for the Program.

(b) Access to Health Information. Agrace shall provide Instructors and Trainees with access to certain Agrace protected health information ("PHI") for educational purposes which may include, but not limited to Agrace patients' plans of care, records and standard clinical materials. Prior to accessing PHI, Instructors and Trainees must sign a confidentiality agreement provided by Agrace. Without limiting any term in the confidentiality agreement, any work completed by Trainee as part of the Program shall not disclose PHI. The Trainer and Trainees are responsible for safeguarding the confidentiality of Agrace patients' at all times. In addition, Trainer shall arrange for Instructors and Trainees to attend appropriate training regarding Agrace's policies and procedures for handling PHI, as described in this Agreement.

(c) Withdraw of Trainee Access. Agrace reserves the right to withdraw or deny Trainee access to Agrace's premises or patients, without prior notice, if Trainee, in the sole opinion of Agrace: (i) constitutes a threat to the health, safety, welfare or harmony of any Agrace patients or employees or to Agrace property; (ii) fails to follow applicable Agrace policies and procedures; or (iii) commits any act of abuse or any illegal act within Agrace or against any Agrace patient.

4. Term and Termination.

(a) Term. The term of this Agreement shall begin on the Effective Date and continue until terminated as provided in this section. In the event of any termination, students participating in the Program shall be allowed to complete the quarter or semester in which they are enrolled.

(b) Termination by Written Notice. This Agreement may be terminated by either party for any reason by giving the other party written notice of termination thirty (30) days' prior to the date of termination.

(c) Termination by Agreement. This Agreement will terminate upon the written agreement of the parties.

(d) Immediate Termination by Agrace for Cause. Agrace may immediately terminate this Agreement if Trainer, Instructors or Trainees no longer meet or is under threat of losing any of the qualifications required by this Agreement or fails to perform their obligations under this Agreement and such failure threatens the health, safety, or welfare of Agrace patients.

5. Status of Instructors and Trainees. Trainees and Instructors are not employees or independent contractors of Agrace and are not entitled to wages or benefits of employees, including Agrace's Workers' Compensation or Unemployment Compensation insurance programs. Trainer shall indemnify Agrace from and against any demands, claims, actions, causes of action, assessments, losses, damages, liabilities, costs and expenses, including, without limitation, interest, penalties and reasonable attorneys' fees, sustained or incurred by Agrace as a result of, arising out of or incidental to, any allegation that a Trainee or Instructor is an employee or contractor of Agrace.

6. General Provisions.

(a) Survival. The following sections shall survive termination of this Agreement for any reason: 1(j), 2(b), 2(c), 3(b), 5 and 6.

(b) Waiver. The failure of either party to insist, in any one or more instances, upon performance of any term, covenant or condition of this Agreement shall not be construed as a waiver or relinquishment of any rights granted hereunder or of the future performance of any such term, covenant or condition.

(c) Amendment. This Agreement may be amended or modified only by the written agreement of the parties.

(d) Governing Law. The Agreement, including this Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Wisconsin.

(e) Notices. Any notices required or permitted to be given hereunder by either party to the other may be given by personal delivery in writing or by registered or certified mail, postage prepaid, with return receipt requested, or by electronic facsimile transmission with confirmation sent by first class mail, postage prepaid, addressed as follows:

To Agrace: Agrace HospiceCare, Incorporated
5395 East Cheryl Parkway
Madison, WI 53711
Attn: Lynne S. Myers, FACHE, President/CEO

To Trainer: Minnesota School of Business
Attn: Heather Hakanson
1401 West 76th St
Richfield, MN 55423

With a copy to:
Globe University/Minnesota School of Business
Attn: Ken McCarthy
8089 Globe Drive
Woodbury, MN 55125

Notices given personally or by electronic facsimile transmission will be deemed communicated when delivered, and notices by mail will be presumed communicated on the third (3rd) day after mailing.

(f) Severability. Whenever possible, each provision of this Agreement will be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision will be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provisions or the remaining provisions of this Agreement.

(g) Counterparts. This Agreement may be executed in one or more counterparts, all of which taken together will constitute one and the same instrument. Counterparts signed and returned via facsimile or portable document format ("pdf") shall be deemed to be an original signature.

IN WITNESS WHEREOF, the parties have entered into this Agreement as of the date first written above.

AGRACE:

BY Lynne Myers
Lynne S. Myers, FACHE,
President/CEO

TRAINER:

BY _____

Name: Kenneth J McCarthy

Title: CFO

EXHIBIT A
Program Description

Experiences may be clinical or non-clinical, for example: nursing in home care or the Anderson Inpatient Unit or the Johnson Residence, Social Work, Health information Management, Counseling, Dietetics, Medical Assistant, Medical Administrative Assistant, Massage Therapy and Nursing.

**Experiences may be structured as:**

**Preceptorship**
A defined period of time in which two people (a nurse with a student nurse or an experienced nurse with a new graduate) work together, so that the less experienced person can learn and apply knowledge and skills in the practice setting with the help of the more experienced person.

**Clinical Rotation**
A period in which a medical student in the clinical part of his/her education passes through various 'working' services in 1-4 month blocks.

**Internship**
A period of apprenticeship for a medical school graduate or senior nursing student who serves in a clinical setting for a specified period before beginning a professional practice. Internships are also offered in non-clinical fields for students to receive practical experience in their chosen field before graduation.

**Shadow Experience**
A student or intern closely follows a clinician to gain insight into the role and scope of the discipline.

**Special Project**
A student completes a specific project or research study to gain knowledge or experience in the field before graduation.

**Agrace provides:**

**Coordination** –Agrace coordinates with contracted institutions on fulfilling their requests to assign students to their clinical rotations.

**Support** – Agrace provides administrative support to the contracted institution as identified in the institution's requested application form. This includes but is not limited to: reserving conference rooms, organizing and maintaining confidentiality agreements, and granting appropriate access to premises, supplies, and equipment during the rotation period.

**Orientation** – Agrace provides the student with an overview of the agency, administrative policies/procedures, standards, appropriate technology applications, and practice relevant to the placement type.

Agrace

**JOB DESCRIPTION**

## POSITION

| | | |
|---|---|---|
| **Job Title:** | **Licensed Practical Nurse (Inpatient)** | |
| **Status** | ☒ **Regular** | ☐ **Flex** |
| **FLSA:** | ☐ **Exempt** | ☒ **Non-Exempt** |
| **Dept/Supv Title:** | **Team Leader IPU** | |
| **Driving Position:** | ☐ **Yes** | ☒ **No** |

## SUMMARY

The Licensed Practical Nurse performs direct patient care activities under the direction of an RN within the scope of LPN license and in accordance with accepted standard of practice.

## ESSENTIAL FUNCTIONS

1) Performs basic physical and psychosocial observation and data collection skills*
   a) Collects data through observation of the patient/family's physical and psychosocial needs.
   b) Utilizes data collected from the patient, family and/or significant other and other health care professionals.
   c) Reports observations to an RN in a timely manner so that care can be modified to accommodate patient/family needs.
   d) Documents the relevant data collected in the nursing interview, physical observation and other health data.
   e) Completes observations (including re-observations) within established time frames.
   f) Observes the patient/family on a regular and systematic basis per Agrace Inpatient standards or POC.
   g) Schedules visits to occur based on patient/family needs.
   h) Articulates, identifies, and reports signs and symptoms of client abuse and/or neglect, suicide ideation or violence.
2) Performs patient care tasks according to Agrace standards and the plan of care.
   a) Demonstrates age appropriate care.
   b) Demonstrates proper body mechanics when lifting, bending, kneeling, pushing, and pulling.
   c) Demonstrates proper techniques in application of Standard Precautions.
   d) Demonstrates safe and effective use of DME and other medical equipment and supplies.
   e) Assists in the preparation for admissions of patients.
   f) Assists in and accompanies patients in the admission transfer and discharge procedures. (see #3)
   g) Demonstrates accepted techniques in:
      i) Obtaining vital signs
      ii) Giving a bed bath/spa
      iii) Assisting with showering
      iv) Washing hair
      v) Shaving
      vi) Backrubs
      vii) Assisting with ambulation devices
      viii) Assisting with ADLs
      ix) Transfer techniques Hoyer, easy stand
      x) Clean dressing changes and nursing/treatment procedures to include wound care, central line dressing change*
      xi) Catheter care, Foley insertion, bladder scan and irrigation
      xii) Oral care
      xiii) Skin care
      xiv) Administering a bowel program
      xv) Intake and out-put measurements
      xvi) Collecting specimens
      xvii) Tracheostomy Care to include suctioning *
      xviii) Chest tubes to include site care & system maintenance *
      xix) Phlebotomy/blood draws* SQ insertion*
      xx) Veni puncture, peripheral, accu check *
      xxi) Restraining patients properly when ordered.

## MINIMUM QUALIFICATIONS

- Graduation from an accredited program for Licensed Practical Nurses
- Certification/Registration/Licensure: Current, unrestricted Wisconsin LPN license
- CPR Certification preferred (required within 90 days of hire)

## KNOWLEDGE, SKILLS AND ABILITIES

1. One year nursing experience in hospice, oncology or ICU preferred, or two years relevant health care experience
2. Ability to communicate effectively verbally and in writing.
3. Ability to be flexible and effectively manage priorities, multiple tasks and meet deadlines.
4. Ability to maintain patient confidentiality.

## PHYSICAL DEMANDS

1. Ability to lift 50 pounds.

## HIPAA CATEGORIES FOR ACCESS FOR EMPLOYEES AND VOLUNTEERS

☒ I Full Access: Routine access to patient information as needed to do your assigned job and potential disclosure of patient information with appropriate releases and/or consents.
☐ II Modified Access: Access to patients that you work with, but only some patient information.
☐ III Minimal Access: Access only on as case-by-case basis as assigned by a supervisor.

## ACKNOWLEDGEMENT

I can perform the above essential job duties with or without reasonable accommodations.

☐ Yes ☐ No Initial Here _____

Agrace HospiceCare (Agrace) is an Equal Opportunity Employer. In compliance with the Americans with Disabilities Act, and other state and federal laws, Agrace will provide reasonable accommodations to qualified individuals with disabilities and encourages both prospective employees and incumbents to discuss potential accommodations with the employer. This job description is not considered an employment agreement or contract. The specific statements shown in each section of this job description are not intended to be all-inclusive. They represent typical elements and criteria necessary to successfully perform the position. Management has the exclusive right to alter job responsibilities at any time without notice to meet business and agency needs.

| | | | |
|---|---|---|---|
| Employee: | _____ | _____ | _____ |
| | Print Name | Sign Name | Date |
| Supervisor: | _____ | _____ | _____ |
| | Print Name | Sign Name | Date |

***Supervisor: Return signed job description to Human Resources.***

Agrace HospiceCare

**JOB DESCRIPTION**

## POSITION

| | | |
|---|---|---|
| **Job Title:** | **Registered Nurse - Inpatient** | |
| **Status** | ☒ **Regular** | ☐ **Flex** |
| **FLSA:** | ☐ **Exempt** | ☒ **Non-Exempt** |
| **Dept/Supv Title:** | **IPU/Team Leader** | |
| **Driving Position:** | ☐ **Yes** | ☒ **No** |

## SUMMARY

The Registered Nurse coordinates direct and indirect patient care that is based on nursing process using an interdisciplinary team approach. The RN maintains accountability for nursing practice and for all aspects of nursing care delegated to other personnel within their levels of experience and expertise. The RN is responsible for nursing assessments, interventions, evaluations, documentation and coordination of care.

## ESSENTIAL FUNCTIONS

1. Provides continual assessment of the patient and family's physical, psychosocial and spiritual needs.
   a) Collects data through an assessment of the patient/family's physical, psychosocial and spiritual needs.
   b) Utilizes data collected from the patient, family and/or significant other or other members of the interdisciplinary team and other health care professionals.
   c) Identifies, interprets and documents the relevant assessments collected in the nursing interview, physical assessment and other health data.
   d) Completes assessments (including reassessments) within established time frames.
   e) Assesses the patient/family on a regular and systematic basis based on their needs as outlined in the POC.
   f) Identifies changes in patient condition and promptly initiates appropriate interventions.
   g) Utilizes knowledge of uncomplicated grief and the dying process as appropriate in patient and family assessment, care planning and intervention.
   h) Articulates, identifies, and reports signs and symptoms of client abuse and/or neglect, suicide ideation or violence.
   i) Demonstrates critical thinking skills sufficient to support development of reasonable and achievable outcome measures and establishment of priorities in the planning and provision of care.
   j) Recognizes elements of patient and family systems that are not amenable to change.
   k) Demonstrates appropriate use of physical and psychosocial assessment techniques.
   l) Provides education and interventions to patient and family regarding appropriate nutritional intake as the patient's condition progresses.

2. Develops and documents effective care planning.
   a) Formulates, implements and revises individualized POC according to Agrace standards and practices.
   b) Develops an interdisciplinary focused plan of care including collaboration with the patient and family.
   c) Assess and recognizes changes in patient's condition which indicate a change in level of care.
   d) Provides on-going and timely communication to appropriate person(s) regarding patient status.
   e) Provides age-appropriate assessment and care planning.
   f) Demonstrates critical thinking skills sufficient to support development of reasonable and achievable outcome measures and establishment of priorities in the planning and provision of care.
   g) Communicates effectively with in-home team members, where appropriate, for the coordination and implementation of patient/family care.

3. Applies pain management expertise according to Agrace standards, policies and practices.
   a) Assesses pain on admission and on an on-going basis.
   b) Collaborates with patient, physician, and appropriate members of the interdisciplinary team to develop a plan of care to manage pain.
   c) Plans and implements care utilizing World Health Organization/ Agency for Health Care Policy and Research pain guidelines.
   d) Evaluates and documents effectiveness of interventions.
   e) Uses pain management skills to aggressively intervene and control patient's pain.
   f) Exhibits continued competence in pain management through practice and continuing education.
   g) Demonstrates proficiency in administration of pain medications – this included obtaining peripheral IV access, use of central lines, implanted ports and picc lines, and continuous sub-cutaneous infusions.

4. Evaluates learning needs and provides education to patients and families.
   a) Assesses the need for individualized patient and family education.
   b) Addresses how to meet the educational needs in the appropriate care plans.
   c) Evaluates the effectiveness of patient/family education and changes plans accordingly.
   d) Utilizes resources that have been approved by the appropriate Agrace Clinical Leadership Team and the standards of practice.

5. Effectively participates and acts as an integral part of the IDG.
   a) Acknowledges/respects different values/opinions.
   b) Demonstrates the ability to evaluate his/her own therapeutic involvement, including identification of own stressor and life events that may impact ability to provide care.
   c) Assists staff members, as appropriate, in processing feelings.
   d) Understands the roles of all disciplines on the IDG and utilizes them appropriately.
   e) Participates in staff & team meetings to effectively plan and evaluate services for patient/families.
   f) Demonstrate ability to collaborate with the IDG.

6. Maintains a therapeutic working relationship with the patient and family.
   a) Recognize importance of and maintain professional boundaries.
   b) Utilizes team approach.
   c) Reports coping/relationship difficulties to Team.

7. Efficiently utilizes resources.
   a) Delivers patient care in a cost-effective manner.
   b) Utilizes Agrace equipment/supplies appropriately for patient needs.
   c) Assesses and evaluates needed supplies and medications on a continual basis according to Agrace standards and practices.
   d) Utilizes appropriate staff, including volunteers, to meet patient/family needs in a cost-effective manner.

8. Contributes to the professional development and evaluation of peers, colleagues and partners.
   a) Participates in the clinical orientation of all staff, including volunteer training.
   b) Participates in the education of students and health care professionals of all disciplines.
   c) Shares expertise through role modeling, precepting, mentoring, and/or inservice programs.
   d) Serves as a consultant on hospice and palliative care to other health care providers.
   e) Constructively participates in peer review activities, team member feedback and staff performance as requested.
   f) Teaches hospice philosophy and techniques of pain and symptom management to staff in alternate care settings (nursing homes, hospitals, assisted living facilities etc.).

9. Performs all nursing tasks according to Agrace standards.
   a) Demonstrates proficiency in medication administration including oral, PR, sub-cuteanous, transdermal, peripheral IV access, use of central lines, implanted ports and picc lines, and continuous sub-cutaneous infusions.
   b) Demonstrates proficiency in administration of blood/blood products including assessment of and proper intervention for reactions.
   c) Demonstrates proficiency in phlebotomy/blood draws.
   d) Demonstrates proper body mechanics when lifting, bending, kneeling, pushing, and pulling.
   e) Demonstrates proper techniques in application of Universal Precautions and Sharps handling.
   f) Demonstrates safe and effective use of DME and other medical equipment and supplies.
   g) Demonstrates accepted techniques in nursing procedures.

10. Delegates and supervises nursing care assignments in accordance with the qualifications and abilities of personnel to meet patient and family needs.
    a) Supervises LPNs and CNAs on an ongoing basis.
    b) Seeks verbal and written update from assigned LPN/CNA and update staff about patient on a regular basis.
    c) Provides on-site orientation and supervision of CNA/LPNs on an ongoing basis, in accordance with Agrace standards and practices and applicable law and regulations.

11. Provides adequate nursing coverage for all patients.
    a) Willing to be flexible in rotating shifts when needed (i.e. weekdays and weekends).
    b) Willing to adjust hours as needed to meet changes in census.
    c) Willing to provide coverage during absences of other RNs.

12. Assumes Charge Nurse responsibilities as assigned. These responsibilities include:
    a) Assigns care of current patients to appropriate staff.
    b) Assures adequate staff on current and upcoming shifts.
    c) Takes calls regarding potential patients and follows up with pre-admission requirements/needs.
    d) Facilitates IDG meetings for the Agrace Inpatient Unit.
    e) Supervised staff on shift and assists with the evaluations as requested.
    f) Assists with development and implementation of Agrace Inpatient Unit policies and procedures.
    g) Assigns orientees/students to appropriate staff.
    h) Performs all other duties as assigned.

## EDUCATION & LICENSURE

1. Associate Degree in Nursing
2. Certification/Registration/Licensure: Current, unrestricted Wisconsin RN license
3. CPR Certification preferred (required within 90 days of hire)

## KNOWLEDGE, SKILLS AND ABILITIES

1. One year direct patient-care nursing experience, preferably in ICU, ER, Medical-Surgery, Oncology, or Palliative Care or two years relevant health care experience.
2. Abilities
3. Ability to communicate effectively verbally and in writing.
4. Ability to be flexible and effectively manage priorities, multiple tasks and meet deadlines.
5. Ability to maintain patient confidentiality.

## HIPAA CATEGORIES FOR ACCESS FOR EMPLOYEES AND VOLUNTEERS

☒ I Full Access: Routine access to patient information as needed to do your assigned job and potential disclosure of patient information with appropriate releases and/or consents.
☐ II Modified Access: Access to patients that you work with, but only some patient information.
☐ III Minimal Access: Access only on as case-by-case basis as assigned by a supervisor.

## ACKNOWLEDGEMENT

I can perform the above essential job duties with or without reasonable accommodations.

☐ Yes ☐ No Initial Here _____

Agrace HospiceCare (Agrace) is an Equal Opportunity Employer. In compliance with the Americans with Disabilities Act, and other state and federal laws, Agrace will provide reasonable accommodations to qualified individuals with disabilities and encourages both prospective employees and incumbents to discuss potential accommodations with the employer. This job description is not considered an employment agreement or contract. The specific statements shown in each section of this job description are not intended to be all-inclusive. They represent typical elements and criteria necessary to successfully perform the position. Management has the exclusive right to alter job responsibilities at any time without notice to meet business and agency needs.

Employee: _____ _____ _____
Print Name Sign Name Date

Supervisor: _____ _____ _____
Print Name Sign Name Date

***Supervisor: Return signed job description to Human Resources.***

**Revision History**

| Revision Level | Revision Date (Month/Year) | Section(s) | Description of Change |
|---|---|---|---|
| 1 | 01/2012 | All | Format, new name |
| 2 | | Select One: | Select One: |

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #: (608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: Divine Savior Healthcare

Address: 2817 New Pinery Road

Portage, WI 53901

Telephone: 608-742-4131

B. Type of facility: ☒ Hospital ☒ Nursing Home ☒ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 36 Hospital beds, 6 ICU beds, and 120 Nursing Home beds

D. Types of patients: Community Hospital, Mental Health, Primary Care

E. Administrator of facility: Michael T Decker, President & CEO

F. Director of nursing service: Jan Bauman, Chief Nursing Officer

G. School(s) of nursing utilizing the facility: Herzing, Madison Area Technical College, University of Wisconsin - Madison, University of Wisconsin - OshKosh, Mount Mary Moraine Park, Southwest Technical, Western Technical, Marquette, Lake Superior, Carrol College, Mid State Technical

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulation equipment will be utilized at this site.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? __X__ Yes _____ No

Comments: _____

B. Does the facility agree to cooperate in promoting the nursing school objectives? __X__ Yes _____ No

Comments: _____

C. Are there experiences in the facility available to students to meet clinical objectives? __X__ Yes _____ No

Comments: _____

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

__X__ Yes _____ No

Comments: _____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

__X__ Yes _____ No

Comments: _____

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

No simulations are utilized at this site.

| | |
|---|---|
| Globe University<br>Nursing School | Bachelor of Science in Nursing (BSN)<br>Nursing Program(s) Utilizing Facility/Simulated Setting |
| Kendra Saal<br>Educational Administrator | Dean of Nursing<br>Title |
| Kendra Saal<br>Signature | 8/24/2016<br>Date |
| 612-455-4781<br>Telephone Number | ksaal@msbcollege.edu<br>Email Address |

# CLINICAL EDUCATION AGREEMENT

THIS AGREEMENT made and entered into by and between DIVINE SAVIOR HEALTHCARE, INC., ("FACILITY"), 2817 New Pinery Rd., PO Box 387, Portage, WI 53589, and GLOBE UNIVERSITY, INC. and MINNESOTA SCHOOL OF BUSINESS, INC., 8089 Globe Drive, Woodbury, MN, 55125, hereinafter referred to collectively as the "SCHOOL".

W I T N E S S E T H :

WHEREAS, the SCHOOL is an educational institution seeking specialized training for its students in its Health Sciences Programs including Medical Assistant, Medical Administrative Assistant, Health Care Management, Massage Therapy, and Nursing; and

WHEREAS, FACILITY has demonstrated its training capabilities suitable to the needs of the SCHOOL; and

WHEREAS, the parties need to define their respective rights and responsibilities;

NOW, THEREFORE, in consideration of the mutual undertakings and agreements hereinafter set forth, FACILITY, and the SCHOOL agree as follows:

1. TERM OF THE AGREEMENT

This Agreement shall be for a period of five (5) years commencing on September 01, 2016 and terminating on August 31, 2021.

2. PROGRAM

a. The parties mutually agree that FACILITY shall provide a program of clinical education for the SCHOOL's students. The educational program shall be devised jointly by the SCHOOL and FACILITY's Administrator, or his or her appointed agent or agents, in such a manner as they shall agree to be practical within the guidelines and restrictions established in this Agreement.

b. Student/Trainee Participants (hereinafter called "students")

(1) Selection: The selection of persons to participate in the program is at the joint discretion of the SCHOOL and FACILITY's Administrator or his or her appointed agent or agents, subject to the limitations set forth in this Agreement.

5. INDEPENDENT CONTRACTOR

It is agreed that nothing herein contained is intended or should be construed in any manner as creating or establishing the relationship of co-partners between the parties hereto or as constituting the SCHOOL, its officers, agents, employees, or students, as the agent, representative, or employee of FACILITY for any purpose or in any manner whatsoever. The SCHOOL is to be and shall remain an independent contractor with respect to all services performed under this Agreement. The SCHOOL represents that it has, or will secure at its own expense, all personnel required in performing services under this Agreement. It is agreed that any and all personnel of the SCHOOL or other persons, including SCHOOL students, while engaged in the performance of any work or services required by the SCHOOL under this Agreement, shall have no contractual relationship with FACILITY and shall not be considered employees of FACILITY. Such personnel or other persons, including SCHOOL students, shall not require nor be entitled to any compensation, rights, or benefits of any kind whatsoever from FACILITY, including, without limitation, tenure rights, medical and hospital care, sick and vacation leave, Worker Compensation, Re-employment Compensation, disability, severance pay, tort liability indemnification, and PERA.

6. BACKGROUND CHECKS

The SCHOOL will ensure that criminal background checks have been completed for students prior to participating in clinical experience. Self-disclosure forms and criminal record checks will be kept on file by the SCHOOL. Upon request of the FACILITY such forms will be made available for review for the purpose of assuring compliance with legal and regulatory standards.

7. CANCELLATION

Either the SCHOOL or FACILITY's Administrator may cancel this entire Agreement or any portion thereof with or without cause upon ninety (90) days' written notice delivered by mail or in person; provided, however, that at the time notice is given, any students participating in the program shall be allowed to complete the quarter or semester in which they are enrolled.

**THIS PORTION OF PAGE INTENTIONALLY LEFT BLANK.**

8. NOTICES

Any notice or demand which must be given or made by a party hereto under the terms of this Agreement or any statute or ordinance shall be in writing, and shall be sent certified mail.

Notices to FACILITY shall be sent to:
Divine Savior Healthcare, Inc.
Attn: Gina Nehmer
2817 New Pinery Rd
PO Box 387
Portage, WI 53589
Notice to the SCHOOL shall be sent to:
Minnesota School of Business
Attn: Heather Hakanson
1401 West 76th St
Richfield, MN 55423
With a copy to:
Globe University/Minnesota School of Business
Attn: Ken McCarthy
8089 Globe Drive
Woodbury, MN 55125

9. HEALTH REQUIREMENTS FOR PERSONS WORKING IN PATIENT CARE AREAS

The SCHOOL shall verify that the all SCHOOL'S employees/students coming to FACILITY have been administered a Mantoux test and follow-up, as indicated, within six months (or one year if on a yearly testing program) prior to the employee's/student's start at FACILITY. Documentation shall be kept by SCHOOL at the SCHOOL site and available, if needed, for reference by FACILITY.

The SCHOOL is responsible for verifying that their employee/student has had Mumps, Rubella, Rubeola, Chickenpox and Hepatitis B screening and vaccination, as indicated. Documentation shall be kept by SCHOOL at the SCHOOL site and available, if needed, for reference by FACILITY.

SCHOOL'S employees/students with infectious diseases or any open or dripping lesions on their body must be evaluated in the FACILITY. FACILITY will determine their ability to participate in their duties and counsel the employee/student on precautions to prevent the spread of nosocomial disease.

10. ADA COMPLIANCE

FACILITY agrees that in fulfilling the duties of this Agreement, FACILITY is responsible for complying with the American with Disabilities Act and any regulations promulgated to the Act. The SCHOOL is not responsible for issues or challenges related to compliance with the ADA beyond its own routine use of facilities, services, or other services covered by the ADA.

11. FINANCIAL CONSIDERATIONS

a. The SCHOOL and FACILITY shall each bear their own costs associated with this Agreement and no payment is required by either the SCHOOL or FACILITY to the other party.

b. FACILITY is not required to reimburse the SCHOOL faculty or students for any services rendered to the Facility or its patients pursuant to this Agreement.

12. AMENDMENTS

Any amendment to this Agreement shall be in writing and signed by authorized officers of each party.

13. GOVERNING LAW

All questions concerning the construction, validity and interpretation of this Agreement, and the performance of the obligations imposed by this Agreement, shall be governed by the laws of the State of Minnesota without regard to any principles of conflicts of laws.

14. ENTIRE AGREEMENT

This Agreement constitutes the complete and entire agreement of the parties concerning the matters referred to in it, and supersedes all prior agreements and understandings, whether written or oral.

**THIS PORTION OF PAGE INTENTIONALLY LEFT BLANK.**

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement with the above terms and conditions by the signatures below.

DIVINE SAVIOR HEALTHCARE, INC.

By: _____

Title: VP of Finance

Date: 7/22/16

The FACILITY certifies that the person who executed this Agreement is authorized to do so on behalf of the entity as required by applicable articles, bylaws, resolutions or ordinances.

GLOBE UNIVERSITY, INC.
MINNESOTA SCHOOL OF BUSINESS, INC.

By: _____

Title: CFO

Date: 7/22/16

The SCHOOL certifies that the person who executed this Agreement is authorized to do so on behalf of the entity as required by applicable articles, bylaws, resolutions or ordinances.

**Divine Savior Healthcare**
JOB DESCRIPTION/PERFORMANCE EVALUATION

| **Job Title:** Licensed Practical Nurse | **Employee Name:** |
|---|---|

| **Job Group:** | **Department:** ER, ICU, Med/Surg, OB, OR | **Pay Type:** |
|---|---|---|
| **Reports To:** Nursing Director | **Created on:** | **Revised:** |

| **POSITION SUMMARY:**<br>Provides supportive services, direct and indirect patient care, organizes and coordinates efficient delivery of care. | | | | |
|---|---|---|---|---|
| **I. Essential Duties and Responsibilities** | **E** | **S** | **D** | **U** |
| 1. Provides patient care following nursing and medical orders as delegated by the RN. | | | | |
| 2. Assists in updating and revising plan of care and care flowsheets. | | | | |
| 3. Incorporates patient teaching in the patient plan of care. | | | | |
| 4. Performs technical nursing skills under the direct supervision of the RN safely and according to current policies and procedures. | | | | |
| 5. Maintains up-to-date knowledge with required competencies, including, but not limited to medications, blood and IV therapy. | | | | |
| 6. Recognizes changes in signs and symptoms and promptly reports patient condition to the RN. | | | | |
| 7. Follows the multidisciplinary plan of care/teaching plan to address patient needs. | | | | |
| 8. Documents according to established standards. | | | | |
| 9. Assists other team members through the steps of the nursing process. | | | | |
| **Additional Duties** | | | | |
| 10. Performs other duties as assigned or as opportunities arise. | | | | |

**Comments:**

**Educational Qualifications:**

- Degree from an accredited Practical Nursing program.
- Current Wisconsin license as a Licensed Practical Nurse.
- Current American Heart Association BLS or American Red Cross CPR/AED for Professional Rescuers and Health Care Providers Certification. Non-certified employees must attain certification within 60 days of employment in position.
- Other certifications may be required by individual departments.

**Work Relationship:**

- Reports directly to the Nursing Director of the department.
- Works directly with all nursing staff.
- Occasional contact with staff from other patient care departments.
- Extensive contact with patients/residents.
- Regular contact with families.
- Occasional contact with the public.

**Working Conditions:**

- Work is performed largely in a pleasant hospital environment.
- Frequently works near moving mechanical parts, has risk of electrical shock and radiation
- Occasionally work in outside weather conditions, wet/or humid conditions, fumes or airborne particles and toxic or caustic chemicals
- Regular exposure to hazardous material such as needle punctures, blood and body fluids.
- The noise level in the work environment is usually moderate.

**Physical Requirements:**

- Frequently required to stand, walk, stoop, kneel or crouch.
- Occasionally required to sit or climb.
- Required to use hands to handle or feel objects, tools or controls.
- Frequently lift and/or move up to 25 pounds.
- Occasionally lift and/or move up to 50 pounds of department supplies and equipment.
- Occasionally may need to move patients and/or equipment of more than 100 pounds.
- Requires specific vision abilities for far vision, near vision, depth perception, colors, accommodation and peripheral vision.
- Vision correctable to 20/40.

**Acknowledgement:**

This job description/evaluation describes the general nature and level of work performed by an employee assigned to this position. It does not state or imply that these are the only duties and responsibilities assigned to the job. The employee may be required to perform other job-related duties as requested by the department manager or administration. All requirements are subject to change over time and to possible modification to reasonably accommodate individuals with disabilities.

_____ _____

Director Signature Date

_____ _____

Employee Signature Date

**Divine Savior Healthcare**
JOB DESCRIPTION/PERFORMANCE EVALUATION

| **Job Title:** Registered Nurse | **Employee Name:** |
|---|---|

| **Job Group:** | **Department:** Dialysis, ER, ICU, Infusion Therapy, Med/Surg, OB, OR | **Pay Type:** |
|---|---|---|
| **Reports To:** Nursing Director | **Created on:** | **Revised:** |

| **POSITION SUMMARY:**<br>Plans and provides comprehensive patient care. Manages available nursing resources and collaborates with other members of the healthcare team to provide quality, cost effective patient care. | ___ | ___ | ___ | ___ |
|---|---|---|---|---|
| **I. Essential Duties and Responsibilities** | **E** | **S** | **D** | **U** |
| 1. Provides patient and family focused care throughout stay. | | | | |
| 2. Initiates and follows individualized plan of care. | | | | |
| 3. Documents according to established standards. | | | | |
| 4. Evaluates patient assessments and responses to interventions and takes appropriate action according to established standards. | | | | |
| 5. Establishes and evaluates progress toward mutual goals and measurable outcomes with patients and families. | | | | |
| 6. Acts as a preceptor for other nursing team members through the steps of the nursing process. | | | | |
| 7. Participates in patient and family education as evidenced by teaching documentation in the medical record. | | | | |
| 8. Delegates patient care activities to appropriate personnel and supervises those activities. | | | | |
| 9. Collaborates with members of the multidisciplinary healthcare team to develop effective discharge and referral plans on admission utilizing appropriate organization and community resources. | | | | |
| 10. Accurately and effectively utilizes the patient acuity system (MESH). | | | | |
| 11. Maintains up-to-date knowledge with required competencies. | | | | |
| **Additional Duties** | | | | |
| 12. Performs other duties as assigned or as opportunities arise. | | | | |

**Comments:**

_____
_____
_____
_____
_____

**Educational Qualifications:**

- Associate's or Bachelor's degree from an accredited Nursing program.
- Current Wisconsin license as a Registered Nurse or eligible to take boards for licensure if new Graduate Nurse.
- Current American Heart Association BLS or American Red Cross CPR/AED for Professional Rescuers and Health Care Providers Certification. Non-certified employees must attain certification within 60 days of employment in position.
- Other certifications may be required by individual departments.

**Work Relationship:**

- Reports directly to the Nursing Director of the department.
- Extensive contact with patients and families.
- Works regularly with nursing staff, physicians and staff from other patient care departments.

**Working Conditions:**

- Work is performed largely in a hospital environment.
- Frequently exposed to risk of electrical shock.
- Occasionally works near moving mechanical parts and in outside weather conditions.
- Occasionally exposed to wet and/or humid conditions, fumes or airborne particles, toxic or caustic chemicals and risk of radiation.
- Regularly exposed to hazardous materials such as needle punctures, blood and body fluids.
- The noise level in the work environment is usually moderate.

**Physical Requirements:**

- Frequently required to stand, walk, stoop, kneel or crouch.
- Occasionally required to sit or climb.
- Required to use hands to handle or feel objects, tools or controls.
- Frequently lift and/or move up to 25 pounds.
- Occasionally lift and/or move up to 50 pounds of department supplies and equipment.
- Occasionally may need to move patients and/or equipment of more than 100 pounds.
- Requires specific vision abilities for far vision, near vision, depth perception, colors, accommodation and peripheral vision.
- Vision correctable to 20/40.

**Acknowledgement:**

This job description/evaluation describes the general nature and level of work performed by an employee assigned to this position. It does not state or imply that these are the only duties and responsibilities assigned to the job. The employee may be required to perform other job-related duties as requested by the department manager or administration. All requirements are subject to change over time and to possible modification to reasonably accommodate individuals with disabilities.

_____ _____

Director Signature Date

_____ _____

Employee Signature Date

**Divine Savior Healthcare**
JOB DESCRIPTION/PERFORMANCE EVALUATION

| **Job Title:** Licensed Practical Nurse | **Employee Name:** |
|---|---|

| **Job Group:** | **Department:** Tivoli | **Pay Type:** Non-Exempt |
|---|---|---|
| **Reports To:** Nursing Director | **Created on:** | **Revised:** |

| **POSITION SUMMARY:**<br>Provides supportive services, direct and indirect resident care, organizes and coordinates efficient delivery of care. | | | | |
|---|---|---|---|---|
| **I. Essential Duties and Responsibilities** | **E** | **S** | **D** | **U** |
| 1. Provides person-centered resident care following nursing and medical orders as delegated by the RN. | | | | |
| 2. Documents according to established standards. | | | | |
| 3. Recognizes changes in signs and symptoms and promptly reports resident condition to the RN. | | | | |
| 4. Performs technical nursing skills under the direction of the RN safely and according to current policies and procedures. | | | | |
| 5. Participates in resident and family education as evidenced by teaching documentation in the medical record. | | | | |
| 6. Delegates resident care activities to appropriate personnel and supervises those activities as necessary. | | | | |
| 7. Follows the multidisciplinary plan of care/teaching plan to address resident needs. | | | | |
| 8. Assists other team members through the steps of the nursing process. | | | | |
| 9. Maintains up-to-date knowledge with required competencies | | | | |
| **Additional Duties** | | | | |
| 10. Performs other duties as assigned or as opportunities arise. | | | | |

**Comments:**

**Educational Qualifications:**

- Degree from an accredited Nursing program.
- Current Wisconsin license as a Licensed Practical Nurse or if new Graduate Nurse, eligible to take boards for licensure.
- Current American Heart Association BLS or American Red Cross CPR/AED for Professional Rescuers and Health Care Providers Certification. Non-certified employees must attain certification within 60 days of employment in position.

**Work Relationship:**

- Reports directly to the Nursing Director.
- Extensive contact with residents and families.
- Works regularly with nursing staff, physicians and staff from other patient care departments.

**Working Conditions:**

- Work is performed largely in a nursing home environment or in the patient's home.
- Frequently exposed to risk of electrical shock.
- Occasionally works near moving mechanical parts and in outside weather conditions.
- Occasionally exposed to wet and/or humid conditions, fumes or airborne particles, toxic or caustic chemicals and risk of radiation.
- Regularly exposed to hazardous materials such as needle punctures, blood and body fluids.
- The noise level in the work environment is usually moderate.

**Physical Requirements:**

- Frequently required to stand, walk, stoop, kneel or crouch.
- Occasionally required to sit or climb.
- Required to use hands to handle or feel objects, tools or controls.
- Frequently lift and/or move up to 25 pounds.
- Occasionally lift and/or move up to 50 pounds of department supplies and equipment.
- Occasionally may need to move patients and/or equipment of more than 100 pounds.
- Requires specific vision abilities for far vision, near vision, depth perception, colors, accommodation and peripheral vision.
- Vision correctable to 20/40.

**Acknowledgement:**

This job description/evaluation describes the general nature and level of work performed by an employee assigned to this position. It does not state or imply that these are the only duties and responsibilities assigned to the job. The employee may be required to perform other job-related duties as requested by the department manager or administration. All requirements are subject to change over time and to possible modification to reasonably accommodate individuals with disabilities.

_____ _____

Director Signature Date

_____ _____

Employee Signature Date

**Divine Savior Healthcare**
JOB DESCRIPTION/PERFORMANCE EVALUATION

| **Job Title:** Registered Nurse | **Employee Name:** |
|---|---|

| **Job Group:** | **Department:** Home Care, Tivoli | **Pay Type:** |
|---|---|---|
| **Reports To:** Nursing Director | **Created on:** | **Revised:** |

| **POSITION SUMMARY:**<br>Plans and provides comprehensive patient/resident care. Manages available nursing resources and collaborates with other members of the healthcare team to provide quality, cost effective patient/resident care. | | | | |
|---|---|---|---|---|
| **I. Essential Duties and Responsibilities** | **E** | **S** | **D** | **U** |
| 1. Provides person-centered patient/resident care following nursing and medical orders through individualized plan of care. | | | | |
| 2. Documents according to established standards. | | | | |
| 3. Evaluates patient assessments and responses to interventions and takes appropriate action according to established standards. | | | | |
| 4. Establishes and evaluates progress toward mutual goals and measurable outcomes with patients/residents and families. | | | | |
| 5. Acts as a preceptor for other nursing team members through the steps of the nursing process. | | | | |
| 6. Participates in patient/resident and family education as evidenced by teaching documentation in the medical record. | | | | |
| 7. Delegates patient/resident care activities to appropriate personnel and supervises those activities as necessary. | | | | |
| 8. Collaborates with members of the multidisciplinary healthcare team to develop effective discharge and referral plans on admission utilizing appropriate organization and community resources. | | | | |
| 9. Maintains up-to-date knowledge with required competencies | | | | |
| **Additional Duties** | | | | |
| 10. Performs other duties as assigned or as opportunities arise. | | | | |

**Comments:**

**Educational Qualifications:**

- Degree from an accredited Nursing program.
- Current Wisconsin license as a Registered Nurse or if new Graduate Nurse, eligible to take boards for licensure.
- Current American Heart Association BLS or American Red Cross CPR/AED for Professional Rescuers and Health Care Providers Certification. Non-certified employees must attain certification within 60 days of employment in position.

**Work Relationship:**

- Reports directly to the Nursing Director.
- Extensive contact with patients/residents and families.
- Works regularly with nursing staff, physicians and staff from other patient care departments.

**Working Conditions:**

- Work is performed largely in a nursing home environment or in the patient's home.
- Frequently exposed to risk of electrical shock.
- Occasionally works near moving mechanical parts and in outside weather conditions.
- Occasionally exposed to wet and/or humid conditions, fumes or airborne particles, toxic or caustic chemicals and risk of radiation.
- Regularly exposed to hazardous materials such as needle punctures, blood and body fluids.
- The noise level in the work environment is usually moderate.

**Physical Requirements:**

- Frequently required to stand, walk, stoop, kneel or crouch.
- Occasionally required to sit or climb.
- Required to use hands to handle or feel objects, tools or controls.
- Frequently lift and/or move up to 25 pounds.
- Occasionally lift and/or move up to 50 pounds of department supplies and equipment.
- Occasionally may need to move patients and/or equipment of more than 100 pounds.
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- Vision correctable to 20/40.

**Acknowledgement:**

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_____ _____

Director Signature Date

_____ _____

Employee Signature Date

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: Sauk Prairie Healthcare

Address: 260 26th Street

Prairie du Sac, WI 53578

Telephone: _____

B. Type of facility: ☒ Hospital ☐ Nursing Home ☐ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 36 bed inpatient

D. Types of patients: Acute care hospital and birthing, 4 ICU

E. Administrator of facility: Larry Schroeder, CEO

F. Director of nursing service: Denise Cole - Ouzounian, Vice President of Patient Services

G. School(s) of nursing utilizing the facility: _____

Madison College Reedsburg

University of Wisconsin Senior Nursing Students

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses - No LPNs

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulation equipment utilized at this site.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? X Yes ____ No

Comments: All senior leadership

B. Does the facility agree to cooperate in promoting the nursing school objectives?
X Yes ____ No

Comments: ____

C. Are there experiences in the facility available to students to meet clinical objectives?
X Yes ____ No

Comments: Yes in Med/Surgery

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: ____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

____ Yes X No

Comments: No LPN

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

____

____

____

Globe University
Nursing School

Bachelor of Science in Nursing (BSN)
Nursing Program(s) Utilizing Facility/Simulated Setting

Kendra Saal
Educational Administrator

Dean of Nursing
Title

Kendra Saal
Signature

8/24/2016
Date

612-455-4781
Telephone Number

ksaal@msbcollege.edu
Email Address

# CLINICAL STUDENT AFFILIATION AGREEMENT

**BETWEEN**

**GLOBE UNIVERSITY, INC./MINNESOTA SCHOOL OF BUSINESS, INC.**

**AND**

**SAUK PRARIE HEALTHCARE**

This clinical student affiliation agreement (the "Agreement") is entered into between Globe University, Inc./Minnesota School of Business, Inc., each a Minnesota business corporation, (collectively "GU/MSB") and Sauk Prairie Healthcare (the "Facility"). GU/MSB and Sauk Prairie Healthcare may be referred to throughout this Agreement in the singular as "party" or collectively as "parties."

## RECITALS

**WHEREAS**, GU/MSB has established a nursing education program which has a clinical training component; and

**WHEREAS**, it is in the general interest of the Facility to assist in educating persons to be qualified professionals in nursing and the Facility has suitable clinical facilities and programs for the educational needs of GU/MSB's nursing education program; and

**WHEREAS**, GU/MSB and the Facility wish to cooperate in furnishing a clinical experience for students enrolled in the nursing education program at GU/MSB.

**NOW, THEREFORE**, in consideration of the mutual promises and agreements contained herein, the receipt and sufficiency of which the parties acknowledge the parties agree as follows:

## I. MUTUAL RESPONSIBILITIES

**A.** **Program Definition**. Each clinical experience program which places students at the Facility (the "Program") is governed by and subject to the terms of this Agreement. Each Program shall be listed on Exhibit 1, attached to and incorporated by reference into this Agreement. If subsequent Programs are agreed to between the parties, the parties shall amend the Exhibit to include any additional Programs.

**B.** **Discipline**. GU/MSB and Facility agree to take corrective disciplinary action against a student if the student does not comply with GU/MSB's or the Facility's rules and regulations, respectively. Any disciplinary action shall be carried out according to GU/MSB's policies.

C. **Implementation**. Personnel of GU/MSB and the Facility will communicate and mutually coordinate the scheduling and implementation of the Programs. GU/MSB is responsible for the curriculum and educational objectives of the Programs.

## II. GU/MSB'S RESPONSIBILITIES

A. **Accreditation**. Each Program accepted by Facility shall be accredited by the appropriate accrediting organization. GU/MSB shall inform Facility promptly upon any material change in accreditation status of any of the Programs.

B. **Liaison.** GU/MSB will designate an appropriate instructor as a liaison for each active Program at the Facility. The liaison will provide clinical objectives for the Programs active at the Facility and shall coordinate the placement of all participating students with the Facility.

C. **Education**. GU/MSB faculty will be responsible for the quality of education and shall provide supervision and oversight in a manner consistent with all applicable laws and regulations, and shall provide the academic objectives and guidance for planning, directing and evaluating the students' learning experience. GU/MSB will assure that each student has the educational experience and level of competency to participate in the Programs. GU/MSB shall have control over all phases of the administration of the Programs, curriculum content evaluation, faculty appointments, admission requirements, promotion and graduation, and such other matters pertaining to the nursing education program.

D. **Policies and Regulations**. Facility will inform its faculty and students of the Facility's policies and regulations which relate to the Programs at the Facility. GU/MSB students and faculty are responsible for following all applicable Facility policies and procedures while at the Facility, including but not limited to privacy requirements regarding protected health information.

E. **Liability Insurance.** GU/MSB agrees to maintain professional liability insurance and comprehensive general liability insurance with limits of not less than One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate, covering students and faculty participating in the Programs, and workers' compensation insurance for its faculty and any other employees participating in the Programs at the Facility. If GU/MSB does not provide professional liability insurance for students participating in the Programs, then participating students must have professional liability insurance coverage in amounts reasonably necessary to cover students involved in direct patient care during their participation in the Program. GU/MSB or participating students shall provide certificates evidencing such coverage upon request. GU/MSB shall notify Facility promptly of any cancellation of insurance coverage.

F. **Other Insurance**. GU/MSB will encourage participating students to carry their own health insurance during the term of their participation in the Program. Participating students will not be covered by Facility's workers' compensation coverage and shall be responsible for their own health care costs during their participation in the Program.

G. **Health Immunizations and Clearance.** GU/MSB will maintain a record of students' current immunizations and shall obtain student permission to submit summary information regarding their health status to the Facility and will submit this information to the Facility upon request.

GU/MSB will inform its students that **if** the Facility requires students participating in exposure prone procedures who have tested positive for the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV) to disclose this information to the Facility. In addition, per OSHA (July 6, 1992) each student shall have documentation regarding receiving or declining of the Hepatitis B vaccination series if potentially exposed to blood and body fluids during the programs.

H. **Confidentiality.** GU/MSB agrees that its faculty and all participating students shall keep all patient health information and other proprietary information of the Facility (the "Confidential Information") strictly confidential and shall only use such information in furtherance of the student's clinical experience. GU/MSB, its faculty and participating students will not use or disclose Confidential Information to any third party without express permission from the Facility or otherwise required by law. Confidential Information includes, but is not limited to, protected health information defined pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Section II (H) shall survive termination of this Agreement.

I. **Compliance**. GU/MSB warrants and represents that it has not been convicted of a criminal offense related to health care. GU/MSB shall require its students to comply with all applicable laws, regulations and guidelines and agrees to provide adequate training to its students and employees to ensure such compliance.

J. **Criminal Background Checks.** Participating students for Programs involving direct contact with patients must comply with Wisconsin law requiring criminal background studies. For applicable students, GU/MSB will be responsible for obtaining criminal background checks in accordance with Wisconsin law. Facility requires copies of all student Criminal Background Information/Checks, either electronically or in hardcopy, within 2 weeks of student presence at Facility.

## III. FACILITY RESPONSIBILITIES

A. **Accreditation.** If applicable, the Facility will have and maintain current accreditation by the Joint Commission or any other appropriate and required accreditation.

B. **Policies and Regulations.** The Facility will provide GU/MSB with a copy of its policies and procedures that relate to the Program and shall make such material accessible to the participating students.

C. **Facilities.** Facility will allow GU/MSB students and faculty to use its patient care and patient service facilities for clinical instruction according to a mutually-approved plan. Facility will also allow GU/MSB students and faculty to use common areas such as the cafeteria, library and parking facilities, as available.

D. **Number of Students.** Facility and GU/MSB shall mutually agree on the number of students that will participate in the Programs at any time. Facility may limit the number of participating students in a Program at any time. Facility has the discretion to refuse to accept any specific student for cause or may remove any participating students from a Program at any time for failure to comply with Facility rules, regulations or procedures or for other behavior or actions which endanger patient safety. Except in emergencies or as otherwise provided in this Agreement, the Facility shall consult with GU/MSB prior to removing any student from the Facility.

E. **Insurance.** Facility warrants that it carries professional and general liability insurance with limits of at least $1 million per occurrence and carries other insurance appropriate to the risks and obligations contemplated by this Agreement.

F. **Compliance.** Facility warrants and represents that it has not been convicted of a criminal offense related to health care and has not been debarred, excluded or otherwise been determined to be ineligible to participate in any federal health care program. This Agreement shall terminate immediately in the event that Facility is convicted of a criminal offense related to health care or is debarred, excluded or is otherwise determined to be ineligible to participate in any federal health care program. Facility shall comply with all applicable laws, regulations and guidelines.

## IV. REQUIREMENTS OF STUDENTS

A. **Expenses.** Participating students are encouraged to carry their own health insurance and are responsible for their own health care costs. Participating students are also responsible for their own personal and travel expenses and automobile insurance.

**B.** **Insurance.** If not covered by GU/MSB, participating students with direct patient contact are required to carry professional liability insurance in the amount of $1 million per occurrence and $3 million annual aggregate. Students shall provide certificates evidencing such coverage to GU/MSB and GU/MSB shall be included as a named insured on such policies. Facility shall have no obligation with respect to professional liability insurance for students.

## V. MEDICAL CARE AND INFECTIOUS DISEASE EXPOSURE

**A.** **Injury.** Any participating student who is injured or becomes ill while at the Facility shall immediately report the injury or illness to the Facility and GU/MSB and receive treatment (if available) at the Facility as a private patient or obtain other appropriate treatment they choose. Persons receiving care will be responsible for payment of charges incurred for such care; such charges are not the responsibility of the Facility or GU/MSB.

**B.** **Infectious Disease.** For participating students exposed to an infectious disease at the Facility while participating in the Program, Facility will follow the same policies and procedures required of its employees. Participating students contracting an infectious disease while participating in a Program must report this fact to GU/MSB and to the Facility.

## VI. INDEMNIFICATION

GU/MSB and Facility each will indemnify the other party and hold harmless from any and all claims (including, but not limited to, claims based on professional liability), losses, or expenses, including reasonable attorney fees, arising out of or resulting from a breach of its obligations under this Agreement. This Section VI shall survive termination of this Agreement.

## VII. TERM AND TERMINATION

This Agreement is effective on January 1, 2016 and shall continue for an initial term of five (5) years. Upon the expiration of the initial term, this Agreement shall automatically renew for an annual one (1) year term. This Agreement may be terminated by mutual consent, or by either party at any time and for any reason upon sixty (60) days' written notice to the other party. Any students enrolled in a Program at the time of its termination will be given the opportunity to complete the academic term subject to the terms and conditions of this Agreement.

## VIII. FINANCIAL CONSIDERATION

**A.** **Reimbursement by GU/MSB.** Programs referenced by this Agreement are hosted by the Facility without regard to reimbursement by GU/MSB; and, no such compensation is expected from one party to the other party.

B. **Compensation by Facility.** The Facility is not required to compensate GU/MSB or the participating students or faculty for any services rendered to the Facility or its patients pursuant to this Agreement.

## IX. MISCELLANEOUS PROVISIONS

A. **Prohibition Against Discrimination.** Neither party will discriminate against any person because of race, color, creed, religion, gender, national origin, sexual orientation, veteran's status, marital status, age, disability, status with regard to public assistance or inclusion in any group or class against which discrimination is prohibited by federal, state, or local laws and regulations.

B. **Assignment**. Neither party shall assign or transfer any rights or obligations under this Agreement without the prior written consent of the other party. All provisions of this Agreement are binding upon and inure to the benefit of and are enforceable by or against the parties and their respective heirs, executors, administrators or other legal representatives or permitted assigns.

C. **No Waiver.** No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision of this Agreement shall be construed to be a waiver of such breach. Every right and remedy of each of the parties shall be cumulative and either party, in its sole discretion, may exercise any and all rights or remedies stated in this Agreement or otherwise available at law or in equity.

D. **Counterparts.** This Agreement may be executed in counterparts or by facsimile signature and all such counterparts so executed constitute one agreement binding on all the parties hereto.

E. **Third Party Beneficiary**. This Agreement is solely for the benefit of the parties and their respective successors and permitted assigns, and no other person has any right, benefit, priority or interest under or because of the existence of this Agreement.

F. **Relationship of Parties**. It is agreed that nothing in this Agreement is intended or should be construed as creating a partnership, joint venture or other association between the parties, nor shall either party, its employees, students, agents or representatives be considered employees, agents or representatives of the other party.

G. **Notices.** All notices, consents, requests, demands, instructions or other communications provided for herein shall be in writing and shall be deemed validly given, made and served when (a) delivered personally; (b) sent by certified or registered mail, postage prepaid; (c) sent by reputable overnight delivery

service; or (d) sent by facsimile, transmission confirmed to the contact and address listed below.

If to GU/MSB: Minnesota School of Business
Attn: Kendra Saal, Dean of Nursing
1401 W 76th St, Suite 500
Richfield, MN 55423

Copy to:
Globe University
Attn: Ken McCarthy, CFO
8089 Globe Drive
Woodbury, MN 55125

If to Facility Sauk Prairie Healthcare
Attn: Robbi Bos, VP of Human Resources
206 26TH STREET
PRAIRIE DU SAC, WI 53578

**H.** **Entire Agreement**. This Agreement and Exhibits represent the entire Agreement between the parties.

**I.** **Choice of Law**. This Agreement shall be governed by the laws of the State of Wisconsin without consideration of its choice of laws provisions.

**IN WITNESS WHEREOF**, the parties have duly executed this Agreement by signing below,

**GLOBE UNIVERSITY, INC./MINNESOTA SCHOOL OF BUSINESS, INC.**

By: Kenneth J. McCarthy
Its: CFO
Date: 1/11/16

**SAUK PRARIE HEALTHCARE**

By: Robbi Bos
Its: VP-HR
Date: 1/12/16

**EXHIBIT 1**
**LIST OF EDUCATION PROGRAMS**

Globe University/Minnesota School of Business Baccalaureate Nursing Program

**SAUK PRAIRIE HEALTHCARE (SPH)**
**Job Description**

| | |
|---|---|
| **Job Title:** | **REGISTERED NURSE – ACUTE CARE** |
| **Job Code:** | **100** |
| **Department:** | **Nursing Services** |
| **Reports To:** | **Director of Acute Care/ICU** |
| **FLSA Status:** | **Nonexempt** |

**SUMMARY:** Provide quality, professional, general nursing care to patients. Responsible for assessing, planning, implementing, documenting, and evaluating patient care for a group of patients on the unit. Must adapt appropriately to changes in daily assignments, patient status changes, and unit needs. Responsibilities include following all standards, practices, policies and procedures of unit and SPH.

**ESSENTIAL DUTIES AND RESPONSIBILITIES** include the following. Other duties may be assigned. Incumbents in this position may not perform all of the duties outlined.

Incorporate the SPH organization-wide, and department specific mission and philosophy into the delivery of high quality services. This includes following the guidelines of the department's and the organization's customer service plan in delivering services. All services and interactions will be provided with respect of the importance of confidentiality, high integrity and honesty.

Interact with all individuals with equally high respect and care, regardless of race, national origin, religion, sex, marital status, disability, age, sexual orientation, financial background, or other prohibited category. In addition, each employee is responsible to support a respectful work environment, free from any form of harassment.

Responsible for being competent in knowing techniques and skills, to adjust interactions and care to assure accommodation to individuals of all ages, and diverse backgrounds, or any other protected category.

Responsible to keep informed and current of SPH's activities, and adhere to pertinent information which influences employees' activities as communicated through Administration, Human Resources, Department Directors, payroll attachments, department meetings, Employee Newsletter or other forms of communication.

Perform duties in compliance with regulatory requirements, ie: JC, HFAP, Wisconsin Administrative Codes, OSHA, CMS/Medicare, etc, as well as department-specific requirements.

**POSITION TECHNICAL RESPONSIBILITIES** include the following:

Must use and perpetuate the nursing process (assessing, planning, implementation, and evaluation) throughout the patient's stay. Ensure that patient care is individualized to meet the patient's unique needs and situation.

Initiate, develop and document patient plan of care based on patient assessment and medical diagnosis and set priorities for nursing action in accordance with unit policy. The plan of care will be reviewed/revised every 24 hours at a minimum.

Within the framework of unit requirements, physician orders, and policy and procedures, provide care independently with minimal supervision.

Respond to life threatening situations based upon nursing standards, policies, procedures, and protocol.

Maintain a comprehensive understanding of procedures and treatments and have the ability to explain them to patients at their level of understanding.

Perform or assist with procedures per approved unit policy and procedure.

Observe, record significant condition change, and any reaction for patients. In a timely manner, notify supervisor or physician of change in patient's condition, reaction to drug, treatment, and significant incidents.

Monitor, record and communicate patient condition as appropriate utilizing computerized documentation systems.

Via the electronic medical record (EMR), acknowledge physician's orders by the process of review and verification. Once order is acknowledged, follow through on order or delegate in a timely fashion.

Be proficient in medication administration, including IV therapy, as evidenced by lack of medication errors.

Initiate patient/family education plan and discharge needs according to the individualized needs of the patient/family, as prescribed by physician and/or hospital policy.

Delegates to and collaborates with other health team members in planning and providing care based on patient needs.

Learn and maintain skills and equipment competencies as needed.

Safely care for multiple patients. Maintains a safe environment for patients and uses safety precautions appropriately.

Demonstrates understanding and utilization of Universal Precautions, asepsis and infection control procedures.

Ensures proper handling of specimens.

Floats to other units as necessary.

Participates in department or unit quality improvement activities.

Attends 75% of Unit Meetings.

May have precepting responsibility for another person.

**QUALIFICATIONS:** To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

**EDUCATION and/or EXPERIENCE:** Associate Degree in Nursing required. Effective January 1, 2015: BSN required within 5 years from date of appointment.

**CERTIFICATES, LICENSES, REGISTRATIONS:** Current State of Wisconsin Registered Nurse license is required. Required certifications listed below:

| CERTIFICATION | 3 MONTHS (from hire) | 6 MONTHS (from hire) | 1 YEAR (from hire) | DESIRABLE |
|---|---|---|---|---|
| Advanced Cardiac Life Support (ACLS) | | | | X |
| Basic Life Support (BLS) | X | | | |
| Certified Emergency Nurse (CEN) | | | | |
| Emergency Nurses Pediatric Course (ENPC) | | | | |
| Neonatal Resuscitation Program (NRP) | | | | |
| Pediatric Advanced Life Support (PALS) | | | | |
| Pediatric Emergency Assessment, Recognition, and Stabilization (PEARS) | | X (Effective 6/1/15 for current employees) | | |
| Trauma Nursing Core Course (TNCC) | | | | |
| Sugar & Safe Care, Temperature, Airway, Blood Pressure, Lab Work, Emotional Support (STABLE) | | | | |

**SKILLS AND KNOWLEDGE:** Work consists of moderately complicated procedures and tasks which require independent judgments such as setting task priorities; evaluating results; problem solving; and coordinating with others. Must be able to utilize critical thinking skills to organize nursing care and incorporate the nursing process when problem solving. Commitment to quality and to following SPH and department standards, policies, practices and procedures. Able to present a professional, cheerful, caring and sensitive attitude to patients, their family members, coworkers and visitors. Courtesy, tact and the ability to get along with coworkers as a team member, and the ability to keep sensitive information about patients and others strictly confidential is essential. Ability to communicate well and to explain procedures to patients. Skills in decision-making, problem-solving, good judgment and a broad knowledge of general nursing are required. Skill in understanding, explaining, teaching and motivating people. Must be proficient in EKG analysis.

**PHYSICAL DEMANDS:** The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Independent mobility and full body range of motion needed. Eye-hand coordination, depth perception, finger dexterity and functional visual and speech ability. Ability to wear gloves and other protective

equipment. Frequent standing, walking, bending, crouching, and pushing/pulling. Lifting and lowering of weights from 20 pounds to over 50 pounds. Exposure to skin irritants, lung irritants, infectious diseases, electrical equipment, sharp instruments, toxic materials, and hazardous pathogens such as blood and other body fluids. Following SPH and department standards, policies, practices and procedures minimizes risk from these exposures.

**WORK ENVIRONMENT:** The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

| | |
|---|---|
| **Prepared:** | **July 31, 1998** |
| **Revised Date:** | **November, 2014** |
| **Approved By:** | **Robbi E Bos** |

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: St. Mary's Hospital - Madison

Address: 700 South Park Street

Madison, WI 53515

Telephone: 608-251-6100

B. Type of facility: ☒ Hospital ☐ Nursing Home ☐ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 440 beds

D. Types of patients: full range of inpatient and outpatient

E. Administrator of facility: Jon Rozenfeld, President CEO

F. Director of nursing service: Ginger Malone, Vice President of Patient Care Services

G. School(s) of nursing utilizing the facility: Globe University

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses - No LPNs at the Hospital

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulations will be utilized at this site.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? X Yes ____ No

Comments: _____

B. Does the facility agree to cooperate in promoting the nursing school objectives? X Yes ____ No

Comments: _____

C. Are there experiences in the facility available to students to meet clinical objectives? X Yes ____ No

Comments: _____

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

____ Yes X No

Comments: No LPNs

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

_____

_____

_____

Globe University
Nursing School

Bachelor of Science in Nursing (BSN)
Nursing Program(s) Utilizing Facility/Simulated Setting

Kendra Saal
Educational Administrator

Dean of Nursing
Title

Kendra Saal
Signature

8/24/2016
Date

612-455-4781
Telephone Number

ksaal@msbcollege.edu
Email Address

**ACADEMIC AFFILIATION AGREEMENT**
*Globe University: Health Occupation Programs*
*SSM Health*

This ACADEMIC AFFILIATION AGREEMENT ("Agreement") is effective **September 24, 2015** ("Effective Date") by and between **Globe University** ("SCHOOL") and SSM Health Care Corporation, a Missouri nonprofit corporation, doing business as **SSM Health** and its subsidiaries (each individually and collectively, "FACILITY").

WHEREAS, SCHOOL, in conferring credentials upon its health occupation program students, must provide and certify completion of certain practical learning and/or clinical experience, some of which may involve interaction with patients;

WHEREAS, SCHOOL desires that certain of its students ("Students") and, when appropriate, certain of its faculty members, be permitted to visit and utilize the premises of FACILITY to afford such Students the opportunity to have practical learning and clinical experiences at FACILITY; and

WHEREAS, FACILITY recognizes the need for and desires to aid in the educational development of nursing and ancillary health professionals, including Students, in an operating facility for the provision of health care services to its patients, and is willing to permit SCHOOL's faculty and Students to participate in providing some of those services on its premises to the extent it is reasonable, proper, and professionally acceptable for them to do so.

THEREFORE, it is understood and agreed upon by the parties hereto as follows:

1. **Duties of SCHOOL**.

Prior to assigning Students to FACILITY, SCHOOL shall:

1.1 Designate a member of its faculty ("Faculty Coordinator") to coordinate this Agreement with a designated member of FACILITY's staff, and obtain FACILITY's written or verbal approval of such Faculty Coordinator, which such approval FACILITY shall not unreasonably withhold. The coordination shall include on-site visits when practical and a continuing exchange of information on progress of the program. SCHOOL shall obtain and provide verification of a criminal background check on the Faculty Coordinator as provided by state law for health care workers if the Faculty Coordinator will be on FACILITY's site or will have access to FACILITY's patient medical records or patients. If the Faculty Coordinator will not be on FACILITY's site and will not have access to patient medical records or patients, then a criminal background check will not be required. In the event adverse information is obtained from the criminal background check, SCHOOL shall provide the information obtained to FACILITY. Failure to provide the information obtained shall disqualify the designated Faculty Coordinator from participation at FACILITY. The results of the criminal background check must be satisfactory to FACILITY;

1.2 Recommend for affiliation only those Students who have successfully completed all necessary requirements of SCHOOL's educational program and any appropriate professional requirements, and who have knowledge and skills consistent with an ability to properly discharge the clinical duties or functions associated with the clinical experiences in which the Students will participate;

1.3 Be responsible for orienting Students to those applicable policies and procedures provided by FACILITY to SCHOOL, including standards of The Joint Commission and Students' responsibilities for the cost of his/her food, transportation, clothing and medical expenses, and to such other policies, procedures, rules and regulations as SCHOOL deems appropriate;

1.4 Obtain and provide verification that names, health status reports, including records of any immunizations required by FACILITY, and other pertinent information about each Student to be assigned to FACILITY are maintained at SCHOOL before the beginning date of the Students' assignment at FACILITY;

1.5 Obtain FACILITY's written approval of Students and periods of affiliation;

1.6 Advise Students to maintain the confidential nature of all information which may come to them with regard to patients and FACILITY records during the duration of the program and obtain from each Student a Confidentiality and Security Agreement in the form attached to this Agreement as Exhibit 1;

1.7 Keep all records and reports on each Student's experience;

1.8 Represent and certify that its teaching program for Students involved under this Agreement is accredited and that SCHOOL is responsible for notifying FACILITY within ten (10) days in the event such accreditation is cancelled, withdrawn or otherwise terminated;

1.9 Advise Students that each Student is accountable for costs incurred in receipt of healthcare pursuant to Section 8.4, regardless of health insurance status;

1.10 Obtain and provide verification of a criminal background check as provided by state law for health care workers for each Student prior to that Student's assignment at FACILITY. In the event adverse information is obtained from the criminal background check, SCHOOL shall provide the information to FACILITY after obtaining an Authorization and Release from the Student. In the event such Authorization and Release are not given by the Student, the Student shall be disqualified from participation at FACILITY. The results of the check must be satisfactory to FACILITY. In addition, for FACILITY sites in the state of Missouri, SCHOOL shall comply with the background check provisions of the regional guidelines for allied health/nursing districts of the St. Louis Metropolitan Hospital Council.

1.11 Agree that it and its Students will comply with the purpose and standards recommended by The Joint Commission; and

1.12 In recognition of the fact that the Students and faculty of SCHOOL shall see patient identifiable health information, SCHOOL shall ensure that patient identifiable health information provided by FACILITY to SCHOOL will be treated as confidential in accordance with applicable law and the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA"), as amended. SCHOOL acknowledges that Students must complete the FACILITY's in-service on HIPAA, which will be part of the Students' orientation process.

The following requirements in Sections 1.13 through 1.15 apply for FACILITY sites in the state of Oklahoma:

1.13 SCHOOL/Faculty Coordinator must complete and submit the following two (2) weeks prior to the clinical rotation:

(a) Provide a letter requesting clinical time, dates, department and Student at least two (2) weeks prior to the beginning of the clinical rotation;
(b) Sign a Confidentiality and Security Agreement, if on campus at FACILITY with Students, in the form attached hereto as Exhibit 1;
(c) Provide clinical objectives;
(d) Provide a competency checklist;
(e) Complete a health screening form and appropriate documentation, if on campus at FACILITY with Students;
(f) Provide a copy of license/registration/certification, if on campus at FACILITY with Students; and
(g) All orientation, materials and documentation listed in Section 1.14.

1.14 Each Student must complete and submit the following two (2) weeks prior to the clinical rotation:

(a) Complete FACILITY orientation which includes the following:
(1) Read the general orientation packet and complete the test;
(2) Sign a Confidentiality and Security Agreement, in the form attached hereto as Exhibit 1;
(3) Provide a copy of the Student's current American Heart Association (AHA) Healthcare Provider CPR Training Card, for rotations in clinical areas;
(4) Provide documentation of Occupational Safety and Health Administration (OSHA) tuberculosis and blood borne pathogens education (provided by SCHOOL);
(5) Complete restraint packet or provide documentation that this has been addressed in the school program.
(6) Complete the student health screening form and provide the appropriate documentation, which includes proof of: (i) current PPD (Students with a positive Blood Assay Mycobacterium Tuberculosis (BAMT) test or students with a past positive PPD will need to complete annual symptom survey and provide documentation from a healthcare provider and/or state health department for clearance to work with the public); (ii) proof of two (2) measles, mumps and rubella (MMR) vaccinations (must be official records, not SCHOOL records); (iii) proof of chickenpox by titer or two (2) varicella immunizations; (iv) three (3) hepatitis B immunizations, positive titer or declination; and (v) proof of current flu shot during flu season and Tdap immunization. The only way Students may opt out of the flu or Tdap immunization is a signed document from the Student's health care provider or a statement from the Student's clergy citing the religious conviction that prevents Student from getting the immunization.

1.15 Complete a FACILITY evaluation at the conclusion of the clinical rotation. This form is to be returned to FACILITY's Clinical Education Division

2. **Duties of Faculty Coordinator**.

SCHOOL, through the Faculty Coordinator, shall:

2.1 Select, in cooperation with designated FACILITY personnel, the appropriate clinical experiences for Students;

2.2 Guide, coordinate and evaluate Students' performance at all times while Students are affiliated with FACILITY;

2.3 Meet with FACILITY personnel prior to and following Students' affiliations, and at such times as either party shall deem appropriate, to evaluate Students' performance and clinical experiences; and

2.4 Ensure that Students participate in ongoing training with respect to the learning and clinical experiences at the FACILITY, including but not limited to, being advised of any changes in FACILITY's policies and procedures, which may impact Students' experiences hereunder.

3. **Duties of FACILITY**.

During this Agreement FACILITY shall:

3.1 Provide practical learning and/or clinical experiences to Students assigned to FACILITY;

3.2 Maintain primary responsibility at all times for patient care and total health services;

3.3 Cooperate with the Faculty Coordinator in the selection of any appropriate clinical experiences for Students;

3.4 Provide physical space for faculty members and Students to hold conferences and for their apparel and personal effects;

3.5 Provide SCHOOL with any applicable policies and procedures and inform SCHOOL, through the Faculty Coordinator, of any new applicable procedures and/or policies or any changes in procedures and/or policies which may affect the affiliation described hereunder; and

3.6 Allow Students to perform services for patients only when under the supervision of a registered, licensed or certified professional. Such professional is to be registered, certified or licensed in the discipline in which supervision is provided. Students shall work, perform assignments, and participate in ward rounds, clinics, staff meetings, and in-service educational programs at the discretion of their supervisors designated by FACILITY.

4. **Immediate Removal of Student**.

Upon the request of FACILITY, SCHOOL shall immediately remove a Student or SCHOOL faculty member, including Faculty Coordinator, from FACILITY in the sole discretion of FACILITY, with or without cause; however, FACILITY shall provide SCHOOL with written notice thereof within a reasonable time following the removal.

5. **Insurance**.

5.1 SCHOOL will maintain for each Student and faculty member assigned to FACILITY professional liability insurance in minimum amounts of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate. If SCHOOL procures professional liability coverage that is not on an "occurrence basis," SCHOOL or Student shall, at all times, maintain insurance coverage for medical professional liability directly or indirectly resulting from acts or omissions of SCHOOL or SCHOOL's employees and agents (including Student), occurring in whole or in part during the term of this Agreement ("Continuing Coverage"). In addition, SCHOOL shall maintain general liability insurance on an occurrence basis for SCHOOL and all its Students, employees and faculty members participating in training programs at FACILITY. The limits for general liability shall be One Million Dollars ($1,000,000.00) per occurrence, Two Million Dollars ($2,000,000.00) annual aggregate. SCHOOL shall also maintain workers' compensation insurance for any employees of SCHOOL performing services under this Agreement. SCHOOL shall furnish FACILITY with a certificate of insurance before the beginning date of each Student's assignment at the FACILITY. Such certificate of insurance shall provide that FACILITY shall receive thirty (30) days written notice prior to the effective date of any cancellation of such insurance.

5.2 It is understood that coverage of SCHOOL's Students, employees, and faculty, including Faculty Coordinator, under the above-referenced policies, or an acceptable substitute therefore, shall be a continuing condition of this Agreement. SCHOOL shall be responsible for satisfying any deductible or self-insured retention required by its liability coverage.

6. **Term and Termination**.

This Agreement shall commence on the Effective Date for an initial term of five (5) years unless earlier terminated as provided herein. Thereafter, this Agreement may be renewed upon mutual written agreement. Notwithstanding the foregoing, either party may terminate this Agreement without cause at any time during a term by giving sixty (60) days prior written notice, effective on the date stated therein, provided Students assigned to FACILITY shall be given an opportunity to complete their affiliation if reasonably practicable. Both parties agree to meet at least thirty (30) days prior to the expiration of the initial term of this Agreement and annually thereafter to evaluate the affiliation program and to review this Agreement. In the event the parties fail to appropriately document an extension, and SCHOOL continues to provide Students hereunder, the term of this Agreement shall be deemed to be automatically extended on a day to day basis until terminated by either party upon thirty (30) days prior written notice if the termination is without cause, or if the termination is not without cause, then as provided by the applicable time frame set forth in the Agreement.

7. **Notice**.

Any notice or communication required or permitted to be given under this Agreement shall be served personally, sent by United States certified mail or sent by email to the following address:

| | |
|---|---|
| If to FACILITY: | SSM Health<br>Attn: Contracts<br>10101 Woodfield Lane<br>St. Louis, MO 63132<br>Email: ContractNotices@ssmhc.com |
| If to SCHOOL: | Globe University<br>Attn: Niki Karel<br>8147 Globe Drive<br>Woodbury, MN 55125<br>Email: nkarel@globeuniversity.edu |

Any change to the notice address listed above must be given to the other party in the same manner as described in this section. The date of notice shall be the date of delivery if the notice is personally delivered, the date of mailing if the notice is sent by United States certified mail or the date of transmission if the notice is sent by email. Each party agrees to maintain evidence of the respective notice method utilized.

8. **Miscellaneous**.

8.1 SCHOOL and FACILITY agree that no individual will be discriminated against on the basis of age, race, religion, creed, sex, national origin, disability, sexual orientation or veteran's status.

8.2 Students and faculty members, including Faculty Coordinator, shall remain at all times during this Agreement students and faculty members of SCHOOL and shall in no way be considered servants, agents, or employees of FACILITY. Students are trainees, not employees, and are not to replace FACILITY staff or to be covered by FACILITY's Social Security Workers' Compensation or Unemployment Compensation.

8.3 This Agreement shall not prevent FACILITY from accepting students for affiliation from other educational institutions.

8.4 In the event of accidental injury or illness of any Student or faculty member, FACILITY shall, upon request, provide emergency care at FACILITY, but FACILITY shall not be responsible for follow-up care, hospitalization or costs incurred in providing such care.

8.5 This Agreement shall be governed by and interpreted in accordance with the substantive laws of the State of Missouri, without application of choice of law rules.

8.6 This Agreement shall be binding upon and shall inure to the benefit of both parties and their respective successors, heirs, assigns and legal representatives. Neither this Agreement nor any rights hereunder may be assigned without the prior consent in writing of the non-assigning party; provided, however, that written consent is not

required for FACILITY to assign this Agreement to any entity under common control, or affiliated, with FACILITY.

8.7 Individuals executing this Agreement on behalf of organizations represent and warrant that they have been authorized to do so.

8.8 This Agreement contains the entire understanding of the parties relating to the subject matter of this Agreement. Prior agreements, promises, negotiations or representations between the parties, either oral or written, relating to the subject matter of this Agreement not expressly set forth herein are of no force or effect. Any modifications or amendments hereto must be agreed to by both parties in writing and shall become effective on the date stated therein.

8.9 This Agreement may be signed in one or more counterparts including via facsimile or email, or by electronic signature in accordance with applicable law, all of which shall be considered one and the same agreement, binding on all parties hereto, notwithstanding that both parties are not signatories to the same counterpart. A signed facsimile or photocopy of this Agreement shall be binding on the parties to this Agreement.

8.10 In the event that any sections, paragraphs, sentences, clauses or phrases of this Agreement (individually, "Provision") shall be found invalid, void and/or unenforceable, for any reason, neither this Agreement generally nor the remainder of this Agreement shall thereby be rendered invalid, void and/or unenforceable, but instead each such Provision and (if necessary) other Provisions hereof, shall be reformed by a court of competent jurisdiction so as to effect, insofar as is practicable, the intention of the parties as set forth in this Agreement, and this Agreement shall then be enforced as so reformed. Notwithstanding the preceding sentence, if such court is unable or unwilling to effect such reformation, the remainder of this Agreement shall be construed and given effect as if such invalid, void and/or unenforceable Provision(s) had not been a part hereof.

8.11 The failure of FACILITY or SCHOOL to object to or take affirmative action with respect to any conduct of the other which is in violation of the provisions of this Agreement shall not be construed as a waiver of that violation or of any future violations of the provisions of this Agreement.

8.12 During the term of this Agreement and thereafter, FACILITY and SCHOOL and their employees and students shall hold information in the strictest confidence except as otherwise required by this Agreement or by federal law. Such information includes but is not limited to patient records and peer review and utilization review documents, the terms of this Agreement, and the finances, earnings, volume of business, systems, practices, plans, contracts, and similar information of each party.

8.13 FACILITY is an equal opportunity employer. As part of its affirmative action policies and obligations, FACILITY is subject to and will comply with the provisions governing federal contractors as set forth in 41 CFR 60-1.4(a), 41 CFR 60-741.5(a) and 41 CFR 60-250.5(a), and these regulations are hereby incorporated into this contract by reference.

8.14 SCHOOL represents and warrants to FACILITY that SCHOOL and its owners, employees, agents and any subcontractors (collectively "Personnel") are not: (i) listed on the System for Award Management website ("sam.gov") with an active exclusion; or (ii) suspended or excluded from participation in any federal health care programs, as defined under 42.U.S.C. § 1320a-7b(f), any form of state Medicaid program, and are not listed on the Office of the Inspector General's website ("oig.hhs.gov") (collectively, "Government Payor Programs"). SCHOOL also represents and warrants that to the best of its knowledge there are no pending or threatened governmental investigations that may lead to suspension or exclusion of SCHOOL or Personnel from Government Payor Programs or may be cause for listing on sam.gov or oig.hhs.gov (collectively, an "Investigation"). SCHOOL shall notify FACILITY of the commencement of any Investigation or suspension or exclusion from Government Payor Programs within three (3) business days of SCHOOL's first learning of it. FACILITY shall have the right to immediately terminate this Agreement upon learning of any such Investigation, suspension or exclusion. FACILITY shall be timely kept apprised by SCHOOL of the status of any such Investigation. SCHOOL shall indemnify, defend, and hold FACILITY harmless from any claims, liabilities, fines, and expenses (including reasonable attorneys' fees) incurred as a result of SCHOOL's breach of this paragraph.

8.15 Each FACILITY shall have the authority to determine participation in this Agreement at the sole discretion of the FACILITY. If a FACILITY determines it will not accept Students, a letter will be provided to the SCHOOL.

8.16 Upon execution of this Agreement, all existing individual FACILITY Agreements with SCHOOL will automatically terminate.

**[Remainder of Page Intentionally Left Blank – Signature Page to Follow]**

IN WITNESS WHEREOF, each person signing below represents and warrants that he or she is fully authorized to sign and deliver this Agreement in the capacity set forth beneath his or her signature and the parties hereto have signed this Agreement as of the date and year written below.

SCHOOL:

**Globe University**

By: _____
Name: Kenneth J. McCarthy
Title: Chief Financial Officer
Address: 8147 Globe Drive
Woodbury, MN 55125

Date: 9/30/15

FACILITY:

**SSM Health Care Corporation d/b/a SSM Health**

By: Maggie Fowler
Name: Maggie Fowler
Title: System Vice President/Chief Nursing Officer
Address: 1173 Corporate Lake Drive
St. Louis, MO 63132

Date: October 6, 2015

# EXHIBIT 1

## CONFIDENTIALITY AND SECURITY AGREEMENT

*Employees, Consultants and Volunteers*

I understand that the business entity ("SSM") in which I work, volunteer or provide services has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of patients' health information. SSM must ensure the confidentiality of its propriety information, including, but not limited to, human resources, payroll, fiscal, research, reporting, strategic planning, communications, computer systems, and other information (collectively, with patient identifiable health information, referred to as "Confidential Information").

In the course of my employment or assignment at SSM, I understand that I may come into the possession of Confidential Information. I further understand that I must sign and comply with this Confidentiality and Security Agreement ("Agreement") in order to access Confidential Information. I understand that for purposes of this Agreement, the term "SSM" shall include any subsidiaries or affiliates of SSM Health Care Corporation, doing business as SSM Health.

1. I will access, use and disseminate Confidential Information only when it is necessary to perform my job related duties in accordance with SSM's Policies and Procedures.
2. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
3. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
4. I will not discuss Confidential Information where others can overhear the conversation. I understand that it is not acceptable to discuss Confidential Information even if a patient's name is not used.
5. I will not make any unauthorized transmission, examination, modification or removal of Confidential Information.
6. I have no right to any ownership interest in any information accessed or created by me during my relationship with SSM.
7. I will only access or use systems or devices that I am officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.
8. I will practice good workstation security measures such as locking up digital storage devices when not in use, using screen savers with activated passwords and positioning screens away from public view.
9. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
10. I will use only my officially assigned user ID and password, approved licensed software and devices with virus protection software.
11. I will not share/disclose user IDs or passwords, use tools or techniques to break/exploit security measures or connect to unauthorized networks through the systems or devices.
12. I will notify my manager or appropriate information services contact if my password has been seen, disclosed or otherwise compromised, and I will report activity that violates this Agreement, privacy and security policies or any other incident that could have any adverse impact on Confidential Information.
13. I understand that I should have no expectation of privacy when using SSM information systems. SSM may log, access, review and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
14. I will act in the best interest of SSM and in accordance with its Policies and Procedures at all times during my relationship with SSM and I acknowledge that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or ceasing my relationship with SSM.
15. Upon ceasing my relationship with SSM, I will immediately return to SSM any documents, media or property which constitutes Confidential Information, or which gives me access to Confidential Information.
16. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within SSM, in accordance with SSM's policies, and/or civil/criminal prosecution.

IN WITNESS WHEREOF, by signing below, I represent and warrant that I have read this Agreement and agree to comply with all the terms and conditions stated above.

| Employee/Consultant/Vendor **Signature**: | Primary SSM Entity Name where I work, volunteer or provide service: | Date: |
|---|---|---|
| Employee/Consultant/Vendor **Printed Name**: | Business Name of Employer (if not employed by SSM): | |

# Job Description

| HR Created: | 10/19/2009 | HR Revised: | 5/22/12, 5/23/2013 |
|---|---|---|---|
| Entity Name: | St. Mary's Hospital, Madison | Entity Code: | 0007 |
| Department Name: | Medical/Surgical(3SW) | Department Code: | 1001 |
| Position Title: | Registered Nurse | Job Code: | 70007278 |

## I. Position Summary:

Under the general direction of the Unit Director, the Registered Nurse utilizes the nursing process to identify patient needs, systematically plan and implement a plan of care and continually evaluate the results of that care.

## II. Position Requirements (General):

| | |
|---|---|
| EDUCATION: | Licensure(as required below) signifies education requirements have been met. Bachelor of Science in Nursing preferred. |
| CERTIFICATION, LICENSURE, BONDING: | Current licensure as a Registered Nurse in the State of Wisconsin. Current employees must maintain BLS certification. New hires must achieve certification within 3 months of hire. |
| EXPERIENCE: | Previous healthcare or nursing experience preferred. |
| SPECIAL QUALIFICATIONS: | None |

**Department Specific:**

Provides care for patients with orthopedic and urologic diagnoses. Patients requiring plastic surgery are also cared for on this unit. Diagnoses include, but are not limited to: joint replacement, spine surgery, prostatectomy, TURP, Urology diagnoses, Reconstructive surgery.

## III. Working Conditions

Employees in this position are, or can be, exposed to the following:

| Exposure to | |
|---|---|
| toxic/caustic chemicals | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| extreme conditions, hot or cold | ◉ None ○ Some ○ Frequent ○ Very Frequent |
| dust/fumes/gases (including asbestos) | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| moving mechanical parts | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| potential electric shock | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| x-ray electromagnetic energy | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| high pitched noises | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| needles or other sharp objects | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| blood or body fluids | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| communicable diseases | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| unprotected heights | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| CRT (computer) monitor | ○ None ○ Some ○ Frequent ◉ Very Frequent |

| | |
|---|---|
| frequent, repetitive motions | ○ None ○ Some ○ Frequent ◉ Very Frequent |

## IV. Physical Requirements: (Will be different for each position)

Employees in this position are, or can be, required to possess the following physical capabilities.

| | |
|---|---|
| Lifting, carrying, pushing and/or pulling up to 50 lbs. | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Stooping, kneeling and/or crouching daily | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Standing or walking more than 4 hours a day | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Running to respond to patient emergencies | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| Reaching, grasping, fingering, and/or feeling more than 6 hours a day | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Visual acuity in order to correctly distinguish skin tone variations, evidence of IV infiltration, infection; able to read telemetry, blood pressure gauges, etc. | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Audio acuity in order to correctly distinguish various body sounds (i.e., respirations, heart tones, bowel sounds). | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Audio acuity to discern sounds made by various types of machinery or equipment that would indicate dangerous or improper operation | ○ None ○ Some ○ Frequent ◉ Very Frequent |

Check Age(s) of Population Served (To be completed by Clinical Areas Only)

☐ Newborn ☐ Pediatric Under 14 years ☑ Adolescent 12-17 ☑ Adult 15-59 ☑ Geriatric 60+ years ☐ All ☐ Not Applicable

Rating Scale:

**Does Not Meet Standard:**
Less than 75% of the time does not perform at the "meets standard" level. Requires additional skills, knowledge and/or follow through to bring performance to a consistent level. Requires immediate improvement.

**Meets Standard:**
75 to 95% of the time performs at the "meets standard" level. Consistently achieves or exceeds the standard.

**Exceeds Standard:**
Greater than 95% of the time performs at the "meets standard" level. Serves as a role model. Significantly exceeds expectations taking initiative, rarely requiring supervisory direction, and consistently achieving superior results.

## Section I: SSMHC Core Employee Expectations

The criteria listed under each rating standard are meant as examples to assist in rating. In order to be rated as "exceeds standard" an employee must also consistently achieve all standards in the "meets standard" category.

Quality: Supports the concept of Continuous Quality Improvement by utilizing the techniques and processes to solve problems and (re)design procedures. This relates to both clinical and non-clinical positions.

Does Not Meet Standard
- Not able to identify quality goals
- Does not participate on quality teams
- Resists change
- Needs constant reminders
- Fails to share ideas or suggestions for improvement

Meets Standard
- Participates in quality teams when asked
- Communicates quality concerns to supervisor
- Demonstrates change readiness, adaptability and new ways of doing things
- Completes work/goals on time
- Shares ideas and suggestions for improvement

Exceeds Standard
- Facilitates or leads CQI teams; volunteers to participate
- Catalyst for change

Diversity: Treats employees and customers in manner which demonstrates respect for the individual and creates an environment of inclusiveness.

| Does Not Meet Standard | Meets Standard | Exceeds Standard |
|---|---|---|
| • Member of silos/cliches that exclude others<br>• Fails to recognize needs of others<br>• Does not participate in diversity celebrations | • Demonstrates cultural competence with patients, co-workers and others<br>• Demonstrates inclusive behaviors in the workplace<br>• Attends diversity functions | • Acts as a preceptor/mentor/coach for demonstrating inclusive and welcoming behavior<br>• Serves as chair, leads or actively participates on Employee, Diversity and other Committees |

Communication and Cooperation: Collaborates with all disciplines and departments and works cooperatively to provide services in an efficient manner within department and between departments.

| Does Not Meet Standard | Meets Standard | Exceeds Standard |
|---|---|---|
| • Blames others and points fingers<br>• Withholds information from those that need to know<br>• Does not complete handoffs and/or agreed upon team tasks in a timely manner<br>• Does not follow scripting<br>• Repeatedly represents personal view& instead of team view | • Initiates the chain of command and demonstrates appropriate communication style to resolve issues<br>• Communicates to all those that need to know and completes handoffs<br>• Follows department scripts<br>• Solves problems in the best interest of patients and the entity | • Creates exceptional scripts<br>• Offers ideas to improve oral and written communication<br>• Actively solicits feedback; welcomes constructive criticism<br>• Diffuses conflicts before they start |

Safety: Complies with safety policies and regulations and ensures safety practices for patients, staff, self, and visitors; attends all mandatory safety in-services and safety competence assessments.

| Does Not Meet Standard | Meets Standard | Exceeds Standard |
|---|---|---|
| • Fails to make good choices regarding safe practices; uses unsafe shortcuts or workarounds, and/or fails to use checklists, reminders or protocols<br>• Fails to consistently use two patient identifier protocols<br>• Fails to consistently follow hand hygiene policy<br>• Is not able to verbalize any of the National Patient Safety Goals (NPSG)<br>• Handwriting is often illegible<br>• Fails to consistently follow read back of orders policy and procedure<br>• Fails to coach and/or report known patient occurrences, near misses, unsafe workplace hazards and/or unsafe practices | • Always wears ID Badge and meets dress code requirements<br>• Makes good choices re: safe practices, avoiding unsafe shortcuts or workarounds; uses checklists, reminders and protocols<br>• Utilizes two patient identifier protocols<br>• Always follows hand hygiene policy and procedures<br>• Able to verbalize National Patient Safety Goals (NPSG) with minimal prompting<br>• Initiates fall precautions and restraints within policy and procedures<br>• Always reads back verbal orders<br>• Reports and/or coaches peers re: known patient occurrences; near misses; unsafe workplace hazards and/or unsafe practices | • Competently meets all standards and participates in hospital and employee safety teams<br>• Identifies opportunities to improve patient and employee safety<br>• Performs coaching when unsafe behavioral choices are witnessed |

Personal Accountability: Takes ownership/responsibility to develop solutions, find answers and overcome obstacles to achieving desired results.

| Does Not Meet Standard | Meets Standard | Exceeds Standard |
|---|---|---|
| • Requires prompting<br>• Does not complete work on time<br>• Places blame<br>• Resists coaching<br>• Demonstrates "it is not my job" attitude | • Complies with personnel policies and code of conduct<br>• Actively participates in identifying problems, admits/learns from mistakes and shares with others as appropriate<br>• Responds well to constructive feedback resulting in improved | • Actively problem solves and identifies solutions<br>• Takes personal accountability and is engaged for the success of their work group (informal leader) |

performance

The following expectations (attendance, regulatory, licensure and education) are scored as either "meets standard" or "does not meet standard". They are not measured by the frequencies in the rating scale above.

Attendance: Complies with standards defined in the entity's attendance policy.

| Does Not Meet Standard | Meets Standard |
|---|---|
| • Does not meet attendance standards | • Meets attendance standards |

Regulatory: Complies with, is knowledgeable of, and appropriately follows all regulatory, accreditation, and hospital and departmental policies and procedures within scope of position. Ensures necessary records of compliance are maintained.

| Does Not Meet Standard | Meets Standard |
|---|---|
| • Does not consistently comply with regulatory and accreditation policies and procedures | • Consistently complies with regulatory and accreditation policies and procedures |

Licensure: Maintains appropriate license, registry, or certification, in compliance with hospital policy and/or regulation.

| Does Not Meet Standard | Meets Standard |
|---|---|
| • Lets licensure/credentials expire | • Renews licensure/credentials on or before expiration date |

Education: Completed required education by the due date; including but not limited to: CRP, HIPAA, safety, etc.

| Does Not Meet Standard | Meets Standard |
|---|---|
| • Does not complete required education by due date | • Completes required education on or before due date |

## Section II: SSMHC AEPC Expectations - Exceptional Service Standards

COMPASSION – WE REACH OUT WITH OPENNESS, KINDNESS AND CONCERN.

- Be friendly to patients, families, physicians and coworkers. Smile and use greetings such as good morning, good afternoon, etc. When providing service, introduce yourself, explain your purpose, and ask, "How may I help you?"
- Avoid delays, but if they happen, apologize for any problems they may cause.
- Show concern for patients, families, physicians and coworkers. When they are upset or anxious, listen closely to what they have to say and be supportive.
- Do your part to make sure that everyone feels appreciated, valued, and that they belong. Do not offend, embarrass, or gossip about the people around you or anyone else.

RESPECT – WE HONOR THE WONDER OF THE HUMAN SPIRIT.

- Respect the privacy of patients, families, physicians and coworkers. Share information only on a need-to-know basis. Knock on doors before going in – including patient rooms or offices.
- When you are talking, always use words like "please" and "thank-you," "ma'am" and "sir". Avoid using slang words, acronyms or confusing terms. Use appropriate surnames such as Ms., Mrs., Mr., or Dr., unless asked to do otherwise. Don't use words that could be demeaning like "honey" or "sweetie".
- Be open to new ideas and different points of view.
- Discuss and resolve differences constructively. Go directly to the person(s) involved and share concerns or go to the appropriate manager.

EXCELLENCE – WE EXPECT THE BEST OF OURSELVES AND ONE ANOTHER.

- Use best practices and Continuous Quality Improvement (CQI) to change and make things better. Look for ways to improve and share good ideas.
- Meet the needs of our patients, families, physicians and coworkers. Never say "It's not my job." If you cannot help with something, find the person who can.
- Help each other keep the standards of behavior, and follow policies and procedures, and make safe behavioral choices.
- Accept responsibility for doing your job the right way; be proud of your work. Learn from your mistakes and help others who are learning from their mistakes.
- Consistently report known patient or employee safety events, near misses, workplace hazards and unsafe practices. Immediately "speak up for safety" to avoid patient or employee harm.

STEWARDSHIP – WE USE OUR RESOURCES RESPONSIBLY.

- Use resources wisely and responsibly. Help eliminate waste and share cost saving ideas.
- Be open to new ways of doing things. Accept that there may be changes in direction, priorities, schedules, and

responsibilities.
- Maintain a well organized environment. Pick up trash and pick up after yourself. A clean work area is the responsibility of every employee.

COMMUNITY – WE CULTIVATE RELATIONSHIPS THAT INSPIRE US TO SERVE.

- Welcome new employees. Be supportive. Offer to help and set an example of cooperation.
- Thank patients, families, physicians and all customers for the opportunity to serve them.
- Let patients, families and visitors enter or exit elevators or doors first.

## Section III: Principle Duties, Responsibilities and/or Essential Functions

- Fosters, participates and is knowledgeable in Shared Governance as defined at St. Mary's Hospital using the conceptual framework for nursing practice as a guide. Commits to professional development and visible leadership. Assumes responsibility and accountability for own professional practice, continuing education and competency (i.e., mandatory inservice, staff meetings). Seeks learning opportunities.
- Shares expertise and knowledge with coworkers and peers. Assists in orientation of new nursing personnel and/or performs preceptor role. Supports the activities, decisions and initiative of colleagues.
- Utilizes the nursing process to develop a care plan and deliver patient care. Uses best practice based on literature outcomes, integrates into care provisions and decision making. Advocates for patient/family throughout the nursing process. Acts as a clinical resource to and supervises care delivered by the NA. Delegates work appropriately.
- Follows hospital/unit directives; e.g. standards, policies, procedures, protocols. Assumes responsibility for equipment operation and maintenance. Completes documentation according to unit/hospital standards.
- Demonstrates ability to recognize personal values and beliefs and recognize own beliefs and values as separate from the patient situation.
- Supports activities of colleagues. Participates in unit and/or housewide quality improvement measures. Contributes as an effective team member. Participates in productive/problem solving dialogue (i.e., offers and/or seeks solutions to issues). Recognizes and supports change.
- Participates in at least 50% of unit staff meetings. A minimum of 3 meetings must be in person, the remainder may be by a remote option. Access individual unit's methods of communication regularly.
- Respects the confidentiality and dignity of patients. Communicates effectively with customers.
- Performs charge nurse role. Communicates with Nursing Supervisor at charge nurse meeting each shift and as unit needs dictate. Assigns and reassigns personnel according to dynamics of unit to maintain a balanced workload for current shifts. In collaboration with the Nursing Supervisor, assesses status of unit, making sure current and following shifts are adequately covered.
- Punctual for reports/breaks. Uses supplies effectively. Completes work within required shift, i.e., end of shift; OT minimal or nonexistent.
- Performs other duties as requested.

I have reviewed these job requirements and verify that I can perform the essential functions of this role.

Printed Name: _____

Signature: _____ Date: _____

# Job Description

| HR Created: | 10/20/2009 | HR Revised: | 05/21/2012, 5/23/2013 |
|---|---|---|---|
| Entity Name: | St. Mary's Hospital, Madison | Entity Code: | 0007 |
| Department Name: | Surg & Specialty ICU | Department Code: | 1306 |
| Position Title: | Registered Nurse | Job Code: | 70007278 |

## I. Position Summary:

Under the general direction of the Unit Director, the Registered Nurse utilizes the nursing process to identify patient needs, systematically plan and implement a plan of care and continually evaluate the results of that care.

## II. Position Requirements (General):

| | |
|---|---|
| EDUCATION: | Licensure(as required below) signifies education requirements have been met. Bachelor of Science in Nursing preferred. |
| CERTIFICATION, LICENSURE, BONDING: | Current licensure as a Registered Nurse in the State of Wisconsin. Current employees must maintain BLS certification. New hires must achieve certification within 3 months of hire. |
| EXPERIENCE: | Previous healthcare or nursing experience preferred. |
| SPECIAL QUALIFICATIONS: | Current employees must maintain ACLS certification. New hires must achieve certification within 6 months of hire. |

**Department Specific:**

Povides care to post surgical cardiovascular and thoracic patients who are critically ill including, but not limited to: Cardiac bypass surgery, Valve replacement, Aneurysm repair, Thoracic surgery. Provides care to medical and surgical neuroscience patients and surgical patients who are critically ill including, but not limited to: Craniotomy, Stroke, Major general surgery and Other critically ill patients with medical neurology diagnoses.

## III. Working Conditions

Employees in this position are, or can be, exposed to the following:

| Exposure to | |
|---|---|
| toxic/caustic chemicals | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| extreme conditions, hot or cold | ◉ None ○ Some ○ Frequent ○ Very Frequent |
| dust/fumes/gases (including asbestos) | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| moving mechanical parts | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| potential electric shock | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| x-ray electromagnetic energy | ○ None ◉ Some ○ Frequent ○ Very Frequent |

| | |
|---|---|
| high pitched noises | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| needles or other sharp objects | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| blood or body fluids | ○ None ○ Some ○ Frequent ◉ Very Frequent |
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| unprotected heights | ○ None ◉ Some ○ Frequent ○ Very Frequent |
| CRT (computer) monitor | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| frequent, repetitive motions | ○ None ○ Some ○ Frequent ◉ Very Frequent |

## IV. Physical Requirements: (Will be different for each position)

Employees in this position are, or can be, required to possess the following physical capabilities.

| | |
|---|---|
| Lifting, carrying, pushing and/or pulling up to 50 lbs. | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Stooping, kneeling and/or crouching daily | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Standing or walking more than 4 hours a day | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Running to respond to patient emergencies | ○ None ○ Some ◉ Frequent ○ Very Frequent |
| Reaching, grasping, fingering, and/or feeling more than 6 hours a day | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Visual acuity in order to correctly distinguish skin tone variations, evidence of IV infiltration, infection; able to read telemetry, blood pressure gauges, etc. | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Audio acuity in order to correctly distinguish various body sounds (i.e., respirations, heart tones, bowel sounds). | ○ None ○ Some ○ Frequent ◉ Very Frequent |
| Audio acuity to discern sounds made by various types of machinery or equipment that would indicate dangerous or improper operation | ○ None ○ Some ○ Frequent ◉ Very Frequent |

Check Age(s) of Population Served (To be completed by Clinical Areas Only)

☐ Newborn ☐ Pediatric Under 14 years ☑ Adolescent 12-17 ☑ Adult 15-59 ☑ Geriatric 60+ years ☐ All ☐ Not Applicable

Rating Scale:

**Does Not Meet Standard:**
Less than 75% of the time does not perform at the "meets standard" level. Requires additional skills, knowledge and/or follow through to bring performance to a consistent level. Requires immediate improvement.

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Does Not Meet Standard
- Not able to identify quality goals
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- Resists change
- Needs constant reminders
- Fails to share ideas or suggestions for improvement

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- Participates in quality teams when asked
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- Demonstrates change readiness, adaptability and new ways of doing things

Exceeds Standard
- Facilitates or leads CQI teams; volunteers to participate
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| • Member of silos/cliches that exclude others<br>• Fails to recognize needs of others<br>• Does not participate in diversity celebrations | • Demonstrates cultural competence with patients, co-workers and others<br>• Demonstrates inclusive behaviors in the workplace<br>• Attends diversity functions | • Acts as a preceptor/mentor/coach for demonstrating inclusive and welcoming behavior<br>• Serves as chair, leads or actively participates on Employee, Diversity and other Committees |

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Safety: Complies with safety policies and regulations and ensures safety practices for patients, staff, self, and visitors; attends all mandatory safety in-services and safety competence assessments.

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| • Fails to make good choices regarding safe practices; uses unsafe shortcuts or workarounds, and/or fails to use checklists, reminders or protocols<br>• Fails to consistently use two patient identifier protocols<br>• Fails to consistently follow hand hygiene policy<br>• Is not able to verbalize any of the National Patient Safety Goals (NPSG)<br>• Handwriting is often illegible<br>• Fails to consistently follow read back of orders policy and procedure<br>• Fails to coach and/or report known patient occurrences, near misses, unsafe workplace hazards and/or unsafe practices | • Always wears ID Badge and meets dress code requirements<br>• Makes good choices re: safe practices, avoiding unsafe shortcuts or workarounds; uses checklists, reminders and protocols<br>• Utilizes two patient identifier protocols<br>• Always follows hand hygiene policy and procedures<br>• Able to verbalize National Patient Safety Goals (NPSG) with minimal prompting<br>• Initiates fall precautions and restraints within policy and procedures<br>• Always reads back verbal orders<br>• Reports and/or coaches peers re: known patient occurrences; near misses; unsafe workplace hazards and/or unsafe practices | • Competently meets all standards and participates in hospital and employee safety teams<br>• Identifies opportunities to improve patient and employee safety<br>• Performs coaching when unsafe behavioral choices are witnessed |

Personal Accountability: Takes ownership/responsibility to develop solutions, find answers and overcome obstacles to achieving desired results.

| Does Not Meet Standard | Meets Standard | Exceeds Standard |
|---|---|---|
| • Requires prompting | • Complies with personnel policies | • Actively problem solves and |

- Does not complete work on time
- Places blame
- Resists coaching
- Demonstrates "it is not my job" attitude

and code of conduct

- Actively participates in identifying problems, admits/learns from mistakes and shares with others as appropriate
- Responds well to constructive feedback resulting in improved performance

identifies solutions

- Takes personal accountability and is engaged for the success of their work group (informal leader)

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- Accept responsibility for doing your job the right way; be proud of your work. Learn from your mistakes and help others who are learning from their mistakes.

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- Use resources wisely and responsibly. Help eliminate waste and share cost saving ideas.
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- Shares expertise and knowledge with coworkers and peers. Assists in orientation of new nursing personnel and/or performs preceptor role. Supports the activities, decisions and initiative of colleagues.
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- Respects the confidentiality and dignity of patients. Communicates effectively with customers.
- Performs charge nurse role. Communicates with Nursing Supervisor at charge nurse meeting each shift and as unit needs dictate. Assigns and reassigns personnel according to dynamics of unit to maintain a balanced workload for current shifts. In collaboration with the Nursing Supervisor, assesses status of unit, making sure current and following shifts are adequately covered.
- Punctual for reports/breaks. Uses supplies effectively. Completes work within required shift, i.e., end of shift; OT minimal or nonexistent.
- Performs other duties as requested.

I have reviewed these job requirements and verify that I can perform the essential functions of this role.

Printed Name: _____

Signature: _____ Date: _____

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: Stoughton Hospital

Address: 900 Ridge St.

Stoughton, WI 53589

Telephone: 608-873-6611

B. Type of facility: ☒ Hospital ☐ Nursing Home ☐ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 35 beds

D. Types of patients: Acute Care - ICU, Swing beds

E. Administrator of facility: Terrence J. Brenny, President CEO

F. Director of nursing service: Tina Strandile, Nurse Manager

G. School(s) of nursing utilizing the facility: Globe Univeristy

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulation equipment will be utilized.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? X Yes ____ No

Comments: _____

B. Does the facility agree to cooperate in promoting the nursing school objectives? X Yes ____ No

Comments: _____

C. Are there experiences in the facility available to students to meet clinical objectives? X Yes ____ No

Comments: _____

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

No simulations

Globe University
Nursing School

Bachelor of Science in Nursing (BSN)
Nursing Program(s) Utilizing Facility/Simulated Setting

Kendra Saal
Educational Administrator

Dean of Nursing
Title

Kendra Saal
Signature

8/24/2016
Date

612-455-4781
Telephone Number

ksaal@msbcollege.edu
Email Address

**ACADEMIC AFFILIATION AGREEMENT**
*Globe University: Health Occupation Programs*
*SSM Health*

This ACADEMIC AFFILIATION AGREEMENT ("Agreement") is effective **September 24, 2015** ("Effective Date") by and between **Globe University** ("SCHOOL") and SSM Health Care Corporation, a Missouri nonprofit corporation, doing business as **SSM Health** and its subsidiaries (each individually and collectively, "FACILITY").

WHEREAS, SCHOOL, in conferring credentials upon its health occupation program students, must provide and certify completion of certain practical learning and/or clinical experience, some of which may involve interaction with patients;

WHEREAS, SCHOOL desires that certain of its students ("Students") and, when appropriate, certain of its faculty members, be permitted to visit and utilize the premises of FACILITY to afford such Students the opportunity to have practical learning and clinical experiences at FACILITY; and

WHEREAS, FACILITY recognizes the need for and desires to aid in the educational development of nursing and ancillary health professionals, including Students, in an operating facility for the provision of health care services to its patients, and is willing to permit SCHOOL's faculty and Students to participate in providing some of those services on its premises to the extent it is reasonable, proper, and professionally acceptable for them to do so.

THEREFORE, it is understood and agreed upon by the parties hereto as follows:

1. **Duties of SCHOOL**.

Prior to assigning Students to FACILITY, SCHOOL shall:

1.1 Designate a member of its faculty ("Faculty Coordinator") to coordinate this Agreement with a designated member of FACILITY's staff, and obtain FACILITY's written or verbal approval of such Faculty Coordinator, which such approval FACILITY shall not unreasonably withhold. The coordination shall include on-site visits when practical and a continuing exchange of information on progress of the program. SCHOOL shall obtain and provide verification of a criminal background check on the Faculty Coordinator as provided by state law for health care workers if the Faculty Coordinator will be on FACILITY's site or will have access to FACILITY's patient medical records or patients. If the Faculty Coordinator will not be on FACILITY's site and will not have access to patient medical records or patients, then a criminal background check will not be required. In the event adverse information is obtained from the criminal background check, SCHOOL shall provide the information obtained to FACILITY. Failure to provide the information obtained shall disqualify the designated Faculty Coordinator from participation at FACILITY. The results of the criminal background check must be satisfactory to FACILITY;

1.2 Recommend for affiliation only those Students who have successfully completed all necessary requirements of SCHOOL's educational program and any appropriate professional requirements, and who have knowledge and skills consistent with an ability to properly discharge the clinical duties or functions associated with the clinical experiences in which the Students will participate;

1.3 Be responsible for orienting Students to those applicable policies and procedures provided by FACILITY to SCHOOL, including standards of The Joint Commission and Students' responsibilities for the cost of his/her food, transportation, clothing and medical expenses, and to such other policies, procedures, rules and regulations as SCHOOL deems appropriate;

1.4 Obtain and provide verification that names, health status reports, including records of any immunizations required by FACILITY, and other pertinent information about each Student to be assigned to FACILITY are maintained at SCHOOL before the beginning date of the Students' assignment at FACILITY;

1.5 Obtain FACILITY's written approval of Students and periods of affiliation;

1.6 Advise Students to maintain the confidential nature of all information which may come to them with regard to patients and FACILITY records during the duration of the program and obtain from each Student a Confidentiality and Security Agreement in the form attached to this Agreement as Exhibit 1;

1.7 Keep all records and reports on each Student's experience;

1.8 Represent and certify that its teaching program for Students involved under this Agreement is accredited and that SCHOOL is responsible for notifying FACILITY within ten (10) days in the event such accreditation is cancelled, withdrawn or otherwise terminated;

1.9 Advise Students that each Student is accountable for costs incurred in receipt of healthcare pursuant to Section 8.4, regardless of health insurance status;

1.10 Obtain and provide verification of a criminal background check as provided by state law for health care workers for each Student prior to that Student's assignment at FACILITY. In the event adverse information is obtained from the criminal background check, SCHOOL shall provide the information to FACILITY after obtaining an Authorization and Release from the Student. In the event such Authorization and Release are not given by the Student, the Student shall be disqualified from participation at FACILITY. The results of the check must be satisfactory to FACILITY. In addition, for FACILITY sites in the state of Missouri, SCHOOL shall comply with the background check provisions of the regional guidelines for allied health/nursing districts of the St. Louis Metropolitan Hospital Council.

1.11 Agree that it and its Students will comply with the purpose and standards recommended by The Joint Commission; and

1.12 In recognition of the fact that the Students and faculty of SCHOOL shall see patient identifiable health information, SCHOOL shall ensure that patient identifiable health information provided by FACILITY to SCHOOL will be treated as confidential in accordance with applicable law and the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA"), as amended. SCHOOL acknowledges that Students must complete the FACILITY's in-service on HIPAA, which will be part of the Students' orientation process.

The following requirements in Sections 1.13 through 1.15 apply for FACILITY sites in the state of Oklahoma:

1.13 SCHOOL/Faculty Coordinator must complete and submit the following two (2) weeks prior to the clinical rotation:

(a) Provide a letter requesting clinical time, dates, department and Student at least two (2) weeks prior to the beginning of the clinical rotation;
(b) Sign a Confidentiality and Security Agreement, if on campus at FACILITY with Students, in the form attached hereto as Exhibit 1;
(c) Provide clinical objectives;
(d) Provide a competency checklist;
(e) Complete a health screening form and appropriate documentation, if on campus at FACILITY with Students;
(f) Provide a copy of license/registration/certification, if on campus at FACILITY with Students; and
(g) All orientation, materials and documentation listed in Section 1.14.

1.14 Each Student must complete and submit the following two (2) weeks prior to the clinical rotation:

(a) Complete FACILITY orientation which includes the following:
(1) Read the general orientation packet and complete the test;
(2) Sign a Confidentiality and Security Agreement, in the form attached hereto as Exhibit 1;
(3) Provide a copy of the Student's current American Heart Association (AHA) Healthcare Provider CPR Training Card, for rotations in clinical areas;
(4) Provide documentation of Occupational Safety and Health Administration (OSHA) tuberculosis and blood borne pathogens education (provided by SCHOOL);
(5) Complete restraint packet or provide documentation that this has been addressed in the school program.
(6) Complete the student health screening form and provide the appropriate documentation, which includes proof of: (i) current PPD (Students with a positive Blood Assay Mycobacterium Tuberculosis (BAMT) test or students with a past positive PPD will need to complete annual symptom survey and provide documentation from a healthcare provider and/or state health department for clearance to work with the public); (ii) proof of two (2) measles, mumps and rubella (MMR) vaccinations (must be official records, not SCHOOL records); (iii) proof of chickenpox by titer or two (2) varicella immunizations; (iv) three (3) hepatitis B immunizations, positive titer or declination; and (v) proof of current flu shot during flu season and Tdap immunization. The only way Students may opt out of the flu or Tdap immunization is a signed document from the Student's health care provider or a statement from the Student's clergy citing the religious conviction that prevents Student from getting the immunization.

1.15 Complete a FACILITY evaluation at the conclusion of the clinical rotation. This form is to be returned to FACILITY's Clinical Education Division

2. **Duties of Faculty Coordinator**.

SCHOOL, through the Faculty Coordinator, shall:

2.1 Select, in cooperation with designated FACILITY personnel, the appropriate clinical experiences for Students;

2.2 Guide, coordinate and evaluate Students' performance at all times while Students are affiliated with FACILITY;

2.3 Meet with FACILITY personnel prior to and following Students' affiliations, and at such times as either party shall deem appropriate, to evaluate Students' performance and clinical experiences; and

2.4 Ensure that Students participate in ongoing training with respect to the learning and clinical experiences at the FACILITY, including but not limited to, being advised of any changes in FACILITY's policies and procedures, which may impact Students' experiences hereunder.

3. **Duties of FACILITY**.

During this Agreement FACILITY shall:

3.1 Provide practical learning and/or clinical experiences to Students assigned to FACILITY;

3.2 Maintain primary responsibility at all times for patient care and total health services;

3.3 Cooperate with the Faculty Coordinator in the selection of any appropriate clinical experiences for Students;

3.4 Provide physical space for faculty members and Students to hold conferences and for their apparel and personal effects;

3.5 Provide SCHOOL with any applicable policies and procedures and inform SCHOOL, through the Faculty Coordinator, of any new applicable procedures and/or policies or any changes in procedures and/or policies which may affect the affiliation described hereunder; and

3.6 Allow Students to perform services for patients only when under the supervision of a registered, licensed or certified professional. Such professional is to be registered, certified or licensed in the discipline in which supervision is provided. Students shall work, perform assignments, and participate in ward rounds, clinics, staff meetings, and in-service educational programs at the discretion of their supervisors designated by FACILITY.

4. **Immediate Removal of Student**.

Upon the request of FACILITY, SCHOOL shall immediately remove a Student or SCHOOL faculty member, including Faculty Coordinator, from FACILITY in the sole discretion of FACILITY, with or without cause; however, FACILITY shall provide SCHOOL with written notice thereof within a reasonable time following the removal.

5. **Insurance**.

5.1 SCHOOL will maintain for each Student and faculty member assigned to FACILITY professional liability insurance in minimum amounts of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate. If SCHOOL procures professional liability coverage that is not on an "occurrence basis," SCHOOL or Student shall, at all times, maintain insurance coverage for medical professional liability directly or indirectly resulting from acts or omissions of SCHOOL or SCHOOL's employees and agents (including Student), occurring in whole or in part during the term of this Agreement ("Continuing Coverage"). In addition, SCHOOL shall maintain general liability insurance on an occurrence basis for SCHOOL and all its Students, employees and faculty members participating in training programs at FACILITY. The limits for general liability shall be One Million Dollars ($1,000,000.00) per occurrence, Two Million Dollars ($2,000,000.00) annual aggregate. SCHOOL shall also maintain workers' compensation insurance for any employees of SCHOOL performing services under this Agreement. SCHOOL shall furnish FACILITY with a certificate of insurance before the beginning date of each Student's assignment at the FACILITY. Such certificate of insurance shall provide that FACILITY shall receive thirty (30) days written notice prior to the effective date of any cancellation of such insurance.

5.2 It is understood that coverage of SCHOOL's Students, employees, and faculty, including Faculty Coordinator, under the above-referenced policies, or an acceptable substitute therefore, shall be a continuing condition of this Agreement. SCHOOL shall be responsible for satisfying any deductible or self-insured retention required by its liability coverage.

6. **Term and Termination**.

This Agreement shall commence on the Effective Date for an initial term of five (5) years unless earlier terminated as provided herein. Thereafter, this Agreement may be renewed upon mutual written agreement. Notwithstanding the foregoing, either party may terminate this Agreement without cause at any time during a term by giving sixty (60) days prior written notice, effective on the date stated therein, provided Students assigned to FACILITY shall be given an opportunity to complete their affiliation if reasonably practicable. Both parties agree to meet at least thirty (30) days prior to the expiration of the initial term of this Agreement and annually thereafter to evaluate the affiliation program and to review this Agreement. In the event the parties fail to appropriately document an extension, and SCHOOL continues to provide Students hereunder, the term of this Agreement shall be deemed to be automatically extended on a day to day basis until terminated by either party upon thirty (30) days prior written notice if the termination is without cause, or if the termination is not without cause, then as provided by the applicable time frame set forth in the Agreement.

7. **Notice**.

Any notice or communication required or permitted to be given under this Agreement shall be served personally, sent by United States certified mail or sent by email to the following address:

| | |
|---|---|
| If to FACILITY: | SSM Health<br>Attn: Contracts<br>10101 Woodfield Lane<br>St. Louis, MO 63132<br>Email: ContractNotices@ssmhc.com |
| If to SCHOOL: | Globe University<br>Attn: Niki Karel<br>8147 Globe Drive<br>Woodbury, MN 55125<br>Email: nkarel@globeuniversity.edu |

Any change to the notice address listed above must be given to the other party in the same manner as described in this section. The date of notice shall be the date of delivery if the notice is personally delivered, the date of mailing if the notice is sent by United States certified mail or the date of transmission if the notice is sent by email. Each party agrees to maintain evidence of the respective notice method utilized.

8. **Miscellaneous**.

8.1 SCHOOL and FACILITY agree that no individual will be discriminated against on the basis of age, race, religion, creed, sex, national origin, disability, sexual orientation or veteran's status.

8.2 Students and faculty members, including Faculty Coordinator, shall remain at all times during this Agreement students and faculty members of SCHOOL and shall in no way be considered servants, agents, or employees of FACILITY. Students are trainees, not employees, and are not to replace FACILITY staff or to be covered by FACILITY's Social Security Workers' Compensation or Unemployment Compensation.

8.3 This Agreement shall not prevent FACILITY from accepting students for affiliation from other educational institutions.

8.4 In the event of accidental injury or illness of any Student or faculty member, FACILITY shall, upon request, provide emergency care at FACILITY, but FACILITY shall not be responsible for follow-up care, hospitalization or costs incurred in providing such care.

8.5 This Agreement shall be governed by and interpreted in accordance with the substantive laws of the State of Missouri, without application of choice of law rules.

8.6 This Agreement shall be binding upon and shall inure to the benefit of both parties and their respective successors, heirs, assigns and legal representatives. Neither this Agreement nor any rights hereunder may be assigned without the prior consent in writing of the non-assigning party; provided, however, that written consent is not

required for FACILITY to assign this Agreement to any entity under common control, or affiliated, with FACILITY.

8.7 Individuals executing this Agreement on behalf of organizations represent and warrant that they have been authorized to do so.

8.8 This Agreement contains the entire understanding of the parties relating to the subject matter of this Agreement. Prior agreements, promises, negotiations or representations between the parties, either oral or written, relating to the subject matter of this Agreement not expressly set forth herein are of no force or effect. Any modifications or amendments hereto must be agreed to by both parties in writing and shall become effective on the date stated therein.

8.9 This Agreement may be signed in one or more counterparts including via facsimile or email, or by electronic signature in accordance with applicable law, all of which shall be considered one and the same agreement, binding on all parties hereto, notwithstanding that both parties are not signatories to the same counterpart. A signed facsimile or photocopy of this Agreement shall be binding on the parties to this Agreement.

8.10 In the event that any sections, paragraphs, sentences, clauses or phrases of this Agreement (individually, "Provision") shall be found invalid, void and/or unenforceable, for any reason, neither this Agreement generally nor the remainder of this Agreement shall thereby be rendered invalid, void and/or unenforceable, but instead each such Provision and (if necessary) other Provisions hereof, shall be reformed by a court of competent jurisdiction so as to effect, insofar as is practicable, the intention of the parties as set forth in this Agreement, and this Agreement shall then be enforced as so reformed. Notwithstanding the preceding sentence, if such court is unable or unwilling to effect such reformation, the remainder of this Agreement shall be construed and given effect as if such invalid, void and/or unenforceable Provision(s) had not been a part hereof.

8.11 The failure of FACILITY or SCHOOL to object to or take affirmative action with respect to any conduct of the other which is in violation of the provisions of this Agreement shall not be construed as a waiver of that violation or of any future violations of the provisions of this Agreement.

8.12 During the term of this Agreement and thereafter, FACILITY and SCHOOL and their employees and students shall hold information in the strictest confidence except as otherwise required by this Agreement or by federal law. Such information includes but is not limited to patient records and peer review and utilization review documents, the terms of this Agreement, and the finances, earnings, volume of business, systems, practices, plans, contracts, and similar information of each party.

8.13 FACILITY is an equal opportunity employer. As part of its affirmative action policies and obligations, FACILITY is subject to and will comply with the provisions governing federal contractors as set forth in 41 CFR 60-1.4(a), 41 CFR 60-741.5(a) and 41 CFR 60-250.5(a), and these regulations are hereby incorporated into this contract by reference.

8.14 SCHOOL represents and warrants to FACILITY that SCHOOL and its owners, employees, agents and any subcontractors (collectively "Personnel") are not: (i) listed on the System for Award Management website ("sam.gov") with an active exclusion; or (ii) suspended or excluded from participation in any federal health care programs, as defined under 42.U.S.C. § 1320a-7b(f), any form of state Medicaid program, and are not listed on the Office of the Inspector General's website ("oig.hhs.gov") (collectively, "Government Payor Programs"). SCHOOL also represents and warrants that to the best of its knowledge there are no pending or threatened governmental investigations that may lead to suspension or exclusion of SCHOOL or Personnel from Government Payor Programs or may be cause for listing on sam.gov or oig.hhs.gov (collectively, an "Investigation"). SCHOOL shall notify FACILITY of the commencement of any Investigation or suspension or exclusion from Government Payor Programs within three (3) business days of SCHOOL's first learning of it. FACILITY shall have the right to immediately terminate this Agreement upon learning of any such Investigation, suspension or exclusion. FACILITY shall be timely kept apprised by SCHOOL of the status of any such Investigation. SCHOOL shall indemnify, defend, and hold FACILITY harmless from any claims, liabilities, fines, and expenses (including reasonable attorneys' fees) incurred as a result of SCHOOL's breach of this paragraph.

8.15 Each FACILITY shall have the authority to determine participation in this Agreement at the sole discretion of the FACILITY. If a FACILITY determines it will not accept Students, a letter will be provided to the SCHOOL.

8.16 Upon execution of this Agreement, all existing individual FACILITY Agreements with SCHOOL will automatically terminate.

**[Remainder of Page Intentionally Left Blank – Signature Page to Follow]**

IN WITNESS WHEREOF, each person signing below represents and warrants that he or she is fully authorized to sign and deliver this Agreement in the capacity set forth beneath his or her signature and the parties hereto have signed this Agreement as of the date and year written below.

SCHOOL:

**Globe University**

By: _____
Name: Kenneth J. McCarthy
Title: Chief Financial Officer
Address: 8147 Globe Drive
Woodbury, MN 55125

Date: 9/30/15

FACILITY:

**SSM Health Care Corporation d/b/a SSM Health**

By: Maggie Fowler
Name: Maggie Fowler
Title: System Vice President/Chief Nursing Officer
Address: 1173 Corporate Lake Drive
St. Louis, MO 63132

Date: October 6, 2015

# EXHIBIT 1

## CONFIDENTIALITY AND SECURITY AGREEMENT

*Employees, Consultants and Volunteers*

I understand that the business entity ("SSM") in which I work, volunteer or provide services has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of patients' health information. SSM must ensure the confidentiality of its propriety information, including, but not limited to, human resources, payroll, fiscal, research, reporting, strategic planning, communications, computer systems, and other information (collectively, with patient identifiable health information, referred to as "Confidential Information").

In the course of my employment or assignment at SSM, I understand that I may come into the possession of Confidential Information. I further understand that I must sign and comply with this Confidentiality and Security Agreement ("Agreement") in order to access Confidential Information. I understand that for purposes of this Agreement, the term "SSM" shall include any subsidiaries or affiliates of SSM Health Care Corporation, doing business as SSM Health.

1. I will access, use and disseminate Confidential Information only when it is necessary to perform my job related duties in accordance with SSM's Policies and Procedures.
2. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
3. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
4. I will not discuss Confidential Information where others can overhear the conversation. I understand that it is not acceptable to discuss Confidential Information even if a patient's name is not used.
5. I will not make any unauthorized transmission, examination, modification or removal of Confidential Information.
6. I have no right to any ownership interest in any information accessed or created by me during my relationship with SSM.
7. I will only access or use systems or devices that I am officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.
8. I will practice good workstation security measures such as locking up digital storage devices when not in use, using screen savers with activated passwords and positioning screens away from public view.
9. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
10. I will use only my officially assigned user ID and password, approved licensed software and devices with virus protection software.
11. I will not share/disclose user IDs or passwords, use tools or techniques to break/exploit security measures or connect to unauthorized networks through the systems or devices.
12. I will notify my manager or appropriate information services contact if my password has been seen, disclosed or otherwise compromised, and I will report activity that violates this Agreement, privacy and security policies or any other incident that could have any adverse impact on Confidential Information.
13. I understand that I should have no expectation of privacy when using SSM information systems. SSM may log, access, review and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
14. I will act in the best interest of SSM and in accordance with its Policies and Procedures at all times during my relationship with SSM and I acknowledge that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or ceasing my relationship with SSM.
15. Upon ceasing my relationship with SSM, I will immediately return to SSM any documents, media or property which constitutes Confidential Information, or which gives me access to Confidential Information.
16. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within SSM, in accordance with SSM's policies, and/or civil/criminal prosecution.

IN WITNESS WHEREOF, by signing below, I represent and warrant that I have read this Agreement and agree to comply with all the terms and conditions stated above.

| Employee/Consultant/Vendor **Signature**: | Primary SSM Entity Name where I work, volunteer or provide service: | Date: |
|---|---|---|
| Employee/Consultant/Vendor **Printed Name**: | Business Name of Employer (if not employed by SSM): | |

# Position Description Cover Sheet

## Position Summary:

| | | | |
|---|---|---|---|
| **Position:** | Licensed Practical Nurse | **Job Code:** | 450 |
| **Department:** | Geriatric Psychiatry | **Department Code:** | 1217 |
| **Worksite Location:** | Stoughton Hospital | **Manager:** | Heather Kleinbrook |
| **WiSHHRA Benchmark:** | | **RWHC Benchmark:** | |
| **Probationary Period:** | Six Months | **FLSA Status:** | Non-Exempt (Hourly) |
| **Job Summary:** | The Licensed Practical Nurse is responsible for providing assigned aspects of patient care in accordance with the established plan of care and under the general direction of a Registered Nurse. Delegated assignments to this position will be based on orientation completion and competency proof. | | |

## Position Requirements:

| | |
|---|---|
| **Required Education:** | Associate's Degree<br>Graduate of an accredited Licensed Practical Nursing Program. |
| ***Preferred* Education:** | |
| **Professional Experience:** | New graduates accepted.<br>Prior related experience is preferred. |
| **Licensure:** | Current licensed by the Board of Licensing and Regulation in the State of Wisconsin as Licensed Practical Nurse in good standing |
| **Certification:** | Current BLS certification |
| **Certification Eligible:** | N/A |
| **Special Requirements:** | Non-violent crisis intervention training-every two years on a rolling calendar. |
| **Computer Competency:** | Basic Computer competency skills are expected for this position. All Stoughton Hospital employees have e-mail access and many use a PC to send and retrieve work e-mail; reference internal websites, access electronic health records, and use online learning tools to remain current with continuing education requirements. |
| **Microsoft Office Suite Skills:** | Intermediate Skills - Able to perform fairly detailed formatting, create Word and Excel files, write formulas and prepare charts for reports. |

## Working Conditions:

| | | | |
|---|---|---|---|
| **Toxic Chemicals** | Some of the Time | **Needles and other Sharps** | Frequently |
| **Extreme Temperatures:** | Rarely | **Blood and other Body Fluids** | Frequently |
| **Dust/Fumes/Gas** | Some of the Time | **Communicable Diseases** | Some of the Time |
| **Handling Mechanical Parts** | Some of the Time | **Unprotected Heights** | Rarely |
| **Electric Shock Potential** | Rarely | **Computer Monitors** | Frequently |
| **X-Ray Electromagnetic Energy** | Rarely | **Frequent Repetitive Motions** | Some of the Time |
| **High Pitched Noises** | Some of the Time | | |

## Physical Requirements:

| | | | |
|---|---|---|---|
| **Standing:** | Very Frequently | **Reaching Outward:** | Some of the Time |
| **Walking:** | Very Frequently | **Climbing:** | Some of the Time |
| **Sitting:** | Some of the Time | **Crawling:** | Some of the Time |
| **Handling:** | Very Frequently | **Squatting:** | Some of the Time |
| **Bending:** | Frequently | **Kneeling:** | Some of the Time |
| **Visual Acuity:** | Very Frequently | **Color Vision Required:** | No |
| **Audio Acuity:** | Very Frequently | | |
| | | | |
| **Lifting and Or Carrying** | | **Pushing and or Pulling Per Safe Movement Policy:** | |
| **10 lbs or Less** | Frequently | **1 – 12 lbs** | Frequently |
| **11 – 20 lbs** | Frequently | **13 – 25 lbs** | Frequently |
| **21 – 50 lbs** | Some of the Time | **26 – 40 lbs** | Some of the Time |
| **51 – 100 lbs** | Some of the Time | **41 – 100 lbs** | Some of the Time |
| **Over 100 lbs** | Some of the Time | | |

# Organization Performance Evaluation

## *AAACTS Standards of Performance*

Delivering Excellent Customer Service requires every employee to be committed to "Excellence Standards of Performance." These standards are a code of behavior that clearly communicate the way every employee will act when approaching an internal or external customer or providing a service. Together we will provide service excellence to our customers, to our environment, and to each other. All employees' of Stoughton Hospital are measured on the following:

| Measure | Expectation | Ratings: M=Meets Standards E=Exceeds Standards | | | |
|---|---|---|---|---|---|
| ATTITUDE | Maintains a consistent, friendly, and courteous approach to everyone. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Recognizes diversity, acts respectfully, and appreciates that all individuals are unique. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Maintains a consistent, pleasant disposition. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Ensures own conduct, conversation and tone will only reflect positively on our organization. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Unprofessional body language, conduct or rudeness is never accepted. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| ACCOUNTABILITY | Consistently treats our customer as our first priority. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Works diligently to fix problems immediately or find someone who can. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Admits mistakes and apologizes when needed; avoid becoming defensive, blaming others, or making excuses. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Respects the time and talents of others by responding promptly to requests, emails and voicemails. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Ensures that confidentiality is never compromised. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Attends mandatory inservices and demonstrates knowledge and integration of safety/risk management, infection prevention and performance improvement in daily work. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Has five (5) or less unexpected absence and tardies during evaluation period. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| APPEARANCE | Presents a professional image at all times. Follows the hospital's dress code. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Wears ID badge that is easily read by our customers at all times. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Maintains an uncluttered, neat and safe workplace. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Makes department or work area a welcoming one. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Picks up trash, report things promptly such as burned out lights, overflowing trash, broken items, spills, etc. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |

| | | | | | |
|---|---|---|---|---|---|
| **COMMUNICATION** | Listens respectfully, avoids interrupting, and responds thoughtfully. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Explains to customers what will be done, what to expect and why. Always speaks in terms they understand. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Actively communicates concerns and participates in problem solving | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Adheres to expected scripting:<br>• Introduces self to the customer and making good eye contact with a warm smile.<br>• Always asks "is there anything else I can do for you".<br>• Thank our customers for choosing Stoughton Hospital. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |
| | Follows Stoughton Hospital telephone etiquette. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |
| | Use of profanity, disrespectful language, derogatory personal comments, or inappropriate voice volume is never acceptable. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |

| | | | | | |
|---|---|---|---|---|---|
| **TEAMWORK** | Supports co-workers. Refrains from gossip and negativity as it erodes teamwork. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Responds to requests positively with clear expectations of what can be done to help. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Recognizes that everyone is busy and focuses on performance of own job, rather than the workload of others. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Is welcoming, supportive and helpful to all new employees. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Initiates and participates in the recognition of other's accomplishments. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Responds to call lights/customer requests that have not been answered and offers to help the customer within their qualifications. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Demonstrates knowledge of the hospital's strategic plan, departmental goals, and 90 day plans and works with team to meet objectives. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| | | | | | |
|---|---|---|---|---|---|
| **SERVICE** | Positively reinforces Stoughton Hospital's Mission. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Approaches each encounter as an opportunity to exceed our customer's expectations. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Anticipates customer's needs before they ask, because they may not ask. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Treats everyone encountered as a VIP. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Provides the same excellent customer service to co-workers as we do to customers. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Pays attention to detail. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Shows our customers that we value their time by communicating frequently with them. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Apologizes and explains delays. Actively participates in service recoveries. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Never makes customers feel like an inconvenience. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |

## *Essential Functions and Core Competency Measurements*

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Adheres to Excellence Together standards of performance | Attends 50% of all staff meetings. Participates in ongoing educational activities related to clinical knowledge and professional issues. Seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge. Engages in performance appraisal on a regular basis, identifying areas of strength, as well as where professional development would be beneficial. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Ability to perform essential functions of a Licensed Practical Nurse. | Ability to work independently on the night shift as required. Performs and documents delegated nursing duties, including passing medications and performing treatments in the electronic health record. Records and reports all observed symptoms, reactions, treatments and changes in the patient's condition to the RN in a timely fashion. Assists in and accompanies patients in admission, transfer, and discharge processes. Contributes to the development of Patient Care Plans. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Ability to demonstrate and maintain department specific competencies. | Acquires knowledge and skills appropriate to geriatrics and psychiatry. Reviews all new and revised policies and procedures as required. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Ability to work under the direction of the RN, gather data, and provide intervention and education. | Accurately collects and documents appropriate patient data (blood sugars, temperature, pulse, respirations, weight, blood pressure, intake/output, etc.) Understands and recognizes when situations require urgency in reporting. Assists RN in complicated treatment procedures. Anticipates patient needs and responds accordingly. Promotes health maintenance and patient safety. Reinforces educational needs with patients and families. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Participates in continued personal growth and development. | Engages in performance appraisal on a regular basis, identifying areas of strength, as well as where professional development would be beneficial. Obtains formal or informal feedback regarding one's own practice from patients, peers, professional colleagues, and others. Takes action to achieve goals identified during performance appraisal. Provides rationale for practice beliefs, decisions, and actions as part of the informal or formal evaluation process. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Maintains all other required skills/abilities of a Licensenced Practical Nurse | Communicates effectively orally and in writing. Works and interacts effectively with others. Demonstrates a commitment to practicing self-care, managing stress, and connecting with self and others. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Ability to maintain confidentiality per Hospital policy. | Maintains patient confidentiality within legal and regulatory parameters. Delivers care in a manner that preserves and protects patient autonomy, dignity, a and rights. Reports illegal, incompetent, or impaired practices. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Acquires and maintains current knowledge and competency in nursing practice. | Practice reflects knowledge of current professional practice standards, laws, and regulations. Maintains therapeutic and professional patient-nurse relationship with appropriate professional role boundaries. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations. | Uses the Code of Ethics for Nurses with Interpretive Statements to guide practice. Serves as a patient advocate assisting patients in developing skills for self-advocacy. Contributes to resolving ethical issues of patients, colleagues, or systems. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Demonstrates fiscal responsibility. | Maintains accurate daily charges, efficient use of supplies, and avoids unnecessary overtime. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

## Ages of Populations Served:

**Demonstrates the knowledge and skills necessary to provide care/service based on physical, psychosocial, educational and safety related criteria, appropriate to the age of patients/customers served. The following age categories are serviced by this position:**

| **Geriatric** 60+ Years | **Adult** 18-59 Years | **Adolescent** 12-17 Years | **Pediatric** Under 14 years | **Newborn** |
|---|---|---|---|---|
| Yes | Yes | No | No | No |

____ Evaluates for age appropriate behavior, motor skills and physiological norms.
____ Recognizes patient/customer level of psychosocial development and modifies approach accordingly.
____ Assesses for signs/symptoms of abuse or neglect.

❑ **EMPLOYEE: Place an "x" in the box to the left if you are aware of any breaches in Corporate Ethics. Please attach appropriate documentation and contact Human Resources or Administration with your concerns.**

**I have read and understand the Stoughton Hospital Excellence Together Standards of Performance. As an employee of Stoughton Hospital I am expected to practice these actions anytime on duty for the hospital.**

**I have reviewed the following:**

- ❒ Position Description +
- ❒ Completed education/ training +
- ❒ Standards of Performance +
- ❒ Employee Handbook +
- ❒ Department Specific Competencies

+ *These resources are located on Intranet*

**I agree that my position description** *(located on Intranet)* **accurately reflects the work I perform.**

**I have had an opportunity to review and respond to feed back given to me on this performance evaluation.**

| | |
|---|---|
| **Employee Signature** | **Date** |
| **Manager Signature – I agree that the attached position description accurately reflects the work performed.** | **Date** |
| **Director/Vice-President/President Signature** | **Date** |

# Position Description Cover Sheet

## Position Summary:

| | | | |
|---|---|---|---|
| **Position:** | Registered Nurse | **Job Code:** | 674 |
| **Department:** | Medical Surgical | **Department Code:** | 1001 |
| **Worksite Location:** | Stoughton Hospital | **Manager:** | Kim Prusansky |
| **WiSHHRA Benchmark:** | | **RWHC Benchmark:** | |
| **Probationary Period:** | Six Months | **FLSA Status:** | Professional Exemption Waived |
| **Job Summary:** | The registered nurse position is responsible for providing professional nursing care to patients in assigned units. The registered nurse maintains accountability for his/her own practice and delegates/provides direction to other nursing personnel in the unit in accordance with their level of experience and expertise | | |

## Position Requirements:

| | |
|---|---|
| **Required Education:** | Associate's Degree in Nursing<br>Graduate of an accredited school of Registered Nursing |
| ***Preferred* Education:** | Bachelor's Degree in Nursing |
| **Professional Experience:** | |
| **Licensure:** | Currently licensed by the Board of Licensing and Regulation in the State of Wisconsin as a Registered Nurse in good standing. |
| **Certification:** | Current BLS certification on hire, ACLS certification within 90 days of hire. |
| **Certification Eligible:** | Yes |
| **Special Requirements:** | Non-violent crisis intervention training-every two years on rolling calendar |
| **Computer Competency:** | Basic Computer competency skills are expected for this position. All Stoughton Hospital employees have e-mail access and many use a PC to send and retrieve work e-mail; reference internal websites, access electronic health records, and use online learning tools to remain current with continuing education requirements. |
| **Microsoft Office Suite Skills:** | Beginning Skills - Able to perform basic things such as opening a document, change font, save a document, write a letter. |

## Working Conditions:

| | | | |
|---|---|---|---|
| **Toxic Chemicals** | Some of the Time | **Needles and other Sharps** | Frequently |
| **Extreme Temperatures:** | Rarely | **Blood and other Body Fluids** | Frequently |
| **Dust/Fumes/Gas** | Some of the Time | **Communicable Diseases** | Very Frequently |
| **Handling Mechanical Parts** | Some of the Time | **Unprotected Heights** | Rarely |
| **Electric Shock Potential** | Rarely | **Computer Monitors** | Very Frequently |
| **X-Ray Electromagnetic Energy** | Rarely | **Frequent Repetitive Motions** | Some of the Time |
| **High Pitched Noises** | Some of the Time | | |

## Physical Requirements:

| | | | |
|---|---|---|---|
| **Standing:** | Very Frequently | **Reaching Outward:** | Some of the Time |
| **Walking:** | Very Frequently | **Climbing:** | Some of the Time |
| **Sitting:** | Some of the Time | **Crawling:** | Some of the Time |
| **Handling:** | Frequently | **Squatting:** | Some of the Time |
| **Bending:** | Frequently | **Kneeling:** | Some of the Time |
| **Visual Acuity:** | Very Frequently | **Color Vision Required:** | No |
| **Audio Acuity:** | Very Frequently | | |
| | | | |
| **Lifting and Or Carrying** | | **Pushing and or Pulling Per Safe Movement Policy:** | |
| **10 lbs or Less** | Frequently | **1 – 12 lbs** | Frequently |
| **11 – 20 lbs** | Frequently | **13 – 25 lbs** | Frequently |
| **21 – 50 lbs** | Some of the Time | **26 – 40 lbs** | Some of the Time |
| **51 – 100 lbs** | Some of the Time | **41 – 100 lbs** | Some of the Time |
| **Over 100 lbs** | Some of the Time | | |

# Organization Performance Evaluation

## *AAACTS Standards of Performance*

Delivering Excellent Customer Service requires every employee to be committed to "Excellence Standards of Performance." These standards are a code of behavior that clearly communicate the way every employee will act when approaching an internal or external customer or providing a service. Together we will provide service excellence to our customers, to our environment, and to each other. All employees' of Stoughton Hospital are measured on the following:

| Measure | Expectation | Ratings: M=Meets Standards E=Exceeds Standards | | | |
|---|---|---|---|---|---|
| ATTITUDE | Maintains a consistent, friendly, and courteous approach to everyone. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Recognizes diversity, acts respectfully, and appreciates that all individuals are unique. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Maintains a consistent, pleasant disposition. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Ensures own conduct, conversation and tone will only reflect positively on our organization. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Unprofessional body language, conduct or rudeness is never accepted. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| ACCOUNTABILITY | Consistently treats our customer as our first priority. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Works diligently to fix problems immediately or find someone who can. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Admits mistakes and apologizes when needed; avoid becoming defensive, blaming others, or making excuses. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Respects the time and talents of others by responding promptly to requests, emails and voicemails. | Employee | M | E | |
| | | Manager | M | E | 90-day Action Plan Required |
| | Ensures that confidentiality is never compromised. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Attends mandatory inservices and demonstrates knowledge and integration of safety/risk management, infection prevention and performance improvement in daily work. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Has five (5) or less unexpected absence and tardies during evaluation period. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| APPEARANCE | Presents a professional image at all times. Follows the hospital's dress code. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Wears ID badge that is easily read by our customers at all times. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Maintains an uncluttered, neat and safe workplace. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Makes department or work area a welcoming one. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |
| | Picks up trash, report things promptly such as burned out lights, overflowing trash, broken items, spills, etc. | Employee | M | | |
| | | Manager | M | | 90-day Action Plan Required |

| | | | | | |
|---|---|---|---|---|---|
| COMMUNICATION | Listens respectfully, avoids interrupting, and responds thoughtfully. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Explains to customers what will be done, what to expect and why. Always speaks in terms they understand. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Actively communicates concerns and participates in problem solving | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Adheres to expected scripting:<br>• Introduces self to the customer and making good eye contact with a warm smile.<br>• Always asks "is there anything else I can do for you".<br>• Thank our customers for choosing Stoughton Hospital. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |
| | Follows Stoughton Hospital telephone etiquette. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |
| | Use of profanity, disrespectful language, derogatory personal comments, or inappropriate voice volume is never acceptable. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |

| | | | | | |
|---|---|---|---|---|---|
| TEAMWORK | Supports co-workers. Refrains from gossip and negativity as it erodes teamwork. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Responds to requests positively with clear expectations of what can be done to help. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Recognizes that everyone is busy and focuses on performance of own job, rather than the workload of others. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Is welcoming, supportive and helpful to all new employees. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Initiates and participates in the recognition of other's accomplishments. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Responds to call lights/customer requests that have not been answered and offers to help the customer within their qualifications. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Demonstrates knowledge of the hospital's strategic plan, departmental goals, and 90 day plans and works with team to meet objectives. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| | | | | | |
|---|---|---|---|---|---|
| SERVICE | Positively reinforces Stoughton Hospital's Mission. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Approaches each encounter as an opportunity to exceed our customer's expectations. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Anticipates customer's needs before they ask, because they may not ask. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Treats everyone encountered as a VIP. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Provides the same excellent customer service to co-workers as we do to customers. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Pays attention to detail. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Shows our customers that we value their time by communicating frequently with them. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Apologizes and explains delays. Actively participates in service recoveries. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |
| | Never makes customers feel like an inconvenience. | **Employee** | **M** | | |
| | | **Manager** | **M** | | **90-day Action Plan Required** |

## *Essential Functions and Core Competency Measurements*

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Adheres to Excellence Together standards of performance | Demonstrates compliance with AAACTS standards. Works and interacts effectively with and provides direction to others. Communicates effectively orally and in writing. Maintains confidentiality per Hospital policy. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Ability to perform essential functions of a Registered Nurse including assessment, diagnosis, outcomes, planning and evaluation | Provides professional nursing care to patients in assigned units. Collects comprehensive data pertinent to the patient's health or the situation. Analyzes the assessment data to determine the diagnoses or issues. Identifies expected outcomes for a plan individualized to the patient or the situation. Develops a plan that prescribes strategies and alternatives to attain expected outcomes. Implements the identified plan. Coordinates care delivery and employs strategies to promote health and a safe environment | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Effectively enhances the quality and effectiveness of nursing practice | Demonstrates quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner. Uses creativity and innovation in nursing practice to improve care delivery. Adheres to infection prevention and safety standards as identified by organization. Participates in quality improvement activities. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Maintains knowledge and competency that reflects current nursing practice | Maintains all critical care competencies on an annual basis. Provides age-appropriate care in a culturally and ethnically sensitive manner. Identifying areas of strength, as well as areas in which professional development would be beneficial. Provides rationales for practice beliefs, decisions, and actions as part of the informal and formal evaluation processes. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Interacts with and contributes to the professional development of peers and colleagues | Shares knowledge and skills with peers and colleagues as evidenced by such activities as patient care conferences or presentations at formal or informal meetings. Provides peers with feedback regarding their practice and/or role performance while maintaining a compassionate and caring relationship. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Collaborates with patient, family, and others in the conduct of nursing practice | Communicates with patient, family, and healthcare providers regarding patient care and the nurse's role in the provision of that care. Creates a plan that focusses on outcomes and decisions related to care and delivery of services that communicates with patients and families. Also documents referrals, including provisions for continuity of care. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Integrates ethical provisions in all areas of practice | Uses the Code of Ethics for Nurses with Interpretive Statements (ANA, 2001) to guide practice. Delivers care in a manner that preserves and protects patient autonomy, dignity, and rights. Reports illegal, incompetent, or impaired practices. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Integrates research findings into clinical practice | Utilizes the best available evidence, including research findings, to guide practice decisions. Critically analyzes and interpreting research for application to practice. Uses research findings in the development of policies, procedures, and standards of practice in patient care. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services | Assists the patient and family in identifying and securing appropriate and available services to address health-related needs. Assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, and predictability of the outcome. Informs patients and families about the options, costs, risks, and benefits of treatment and care. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

| Essential Function | Job Specific Core Competency | Rating | | | |
|---|---|---|---|---|---|
| Provides leadership in the professional practice setting and the profession | Displays the ability to define a clear vision, the associated goals, and a plan to implement and measure progress. Directs the coordination of care across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated tasks. | **Employee** | **M** | **E** | |
| | | **Manager** | **M** | **E** | **90-day Action Plan Required** |

## Ages of Populations Served:

**Demonstrates the knowledge and skills necessary to provide care/service based on physical, psychosocial, educational and safety related criteria, appropriate to the age of patients/customers served. The following age categories are serviced by this position:**

| **Geriatric** 60+ Years | **Adult** 18-59 Years | **Adolescent** 12-17 Years | **Pediatric** Under 14 years | **Newborn** |
|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes |

____ Evaluates for age appropriate behavior, motor skills and physiological norms.
____ Recognizes patient/customer level of psychosocial development and modifies approach accordingly.
____ Assesses for signs/symptoms of abuse or neglect.

❑ **EMPLOYEE: Place an "x" in the box to the left if you are aware of any breaches in Corporate Ethics. Please attach appropriate documentation and contact Human Resources or Administration with your concerns.**

**I have read and understand the Stoughton Hospital Excellence Together Standards of Performance. As an employee of Stoughton Hospital I am expected to practice these actions anytime on duty for the hospital.**

**I have reviewed the following:**

- ❒ Position Description +
- ❒ Completed education/ training +
- ❒ Standards of Performance +
- ❒ Employee Handbook +
- ❒ Department Specific Competencies

+ *These resources are located on Intranet*

**I agree that my position description** *(located on Intranet)* **accurately reflects the work I perform.**

**I have had an opportunity to review and respond to feed back given to me on this performance evaluation.**

| | |
|---|---|
| **Employee Signature** | **Date** |
| **Manager Signature – I agree that the attached position description accurately reflects the work performed.** | **Date** |
| **Director/Vice-President/President Signature** | **Date** |

# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8366**
**Madison, WI 53708-8366**
FAX #: (608) 266-2602
**Phone #:** **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53708-8366
E-Mail: dsps@wisconsin.gov
Website: dsps.wisconsin.gov

## BOARD OF NURSING

## CLINICAL FACILITY SELECTION AND SIMULATED SETTING EXPERIENCES

Completion of this form is required for each clinical facility or simulated setting experience as part of the application for authorization to admit students. In addition, this form shall be completed, kept on file in the school of nursing office, and made available to the Board upon request for all clinical facilities and all simulated setting experiences utilized by the nursing school.

I. IDENTIFYING DATA

A. Name of facility: Watertown Regional Medical Center

Address: 125 Hospital Drive

Watertown, WI 53098

Telephone: 920-262-4293 (administration)/920-261-4210 (hospital)

B. Type of facility: ☒ Hospital ☐ Nursing Home ☐ Community Health Agency

☐ Other: _____

C. Number of beds at facility: 60 beds

D. Types of patients: Acute Care

E. Administrator of facility: Jeff Baum, Chairman of the Board of Directors

F. Director of nursing service: Isabelle Garibaldi, Vice President of Patient Care

G. School(s) of nursing utilizing the facility: Madison Area Technical College

II. EXHIBITS (*attach to this form*)

A. Copy of formal agreement signed by:

1. Administrator of facility
2. Educational administrator of nursing school

B. Copy of the position description for:

1. Registered Nurses
2. Licensed Practical Nurses - No LPNs

C. Listing of simulation activities provided and a listing of types of simulation equipment utilized
No simulation equipment utilized.

# Wisconsin Department of Safety and Professional Services

III. PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

A. Have the nursing school objectives been shared with the facility? X Yes ____ No

Comments: _____

B. Does the facility agree to cooperate in promoting the nursing school objectives? X Yes ____ No

Comments: _____

C. Are there experiences in the facility available to students to meet clinical objectives? X Yes ____ No

Comments: _____

D. Is the practice of registered nursing in the facility within the legal scope of practice for registered nurses as defined in Chapter 441.11(4), Wisconsin Statutes? (If no, facility may not be approved.)

X Yes ____ No

Comments: _____

E. Is the practice of licensed practical nursing in the facility within the legal scope of practice for licensed practical nurses as defined in Chapter 441.11(3), Wisconsin Statutes? (If no, facility may not be approved.)

____ Yes X No

Comments: _____

F. If simulated settings are utilized, list the activities, responsibilities and equipment which are included in the learning experience:

No LPNs at hospital

| | |
|---|---|
| Globe University | Bachelor of Science in Nursing (BSN) |
| Nursing School | Nursing Program(s) Utilizing Facility/Simulated Setting |
| Kendra Saal | Dean of Nursing |
| Educational Administrator | Title |
| Kendra Saal | 8/25/2016 |
| Signature | Date |
| 612-455-4781 | ksaal@msbcollege.edu |
| Telephone Number | Email Address |

# CLINICAL EDUCATION AGREEMENT

THIS AGREEMENT made and entered into by and between WATERTOWN REGIONAL MEDICAL CENTER ("CLINIC"), 125 Hospital Drive, Watertown, WI 53098, and GLOBE UNIVERSITY, INC. and MINNESOTA SCHOOL OF BUSINESS, INC., 8089 Globe Drive, Woodbury, MN, 55125, hereinafter referred to collectively as the "SCHOOL".

W I T N E S S E T H :

WHEREAS, the SCHOOL is an educational institution seeking specialized training for its students in its Health Sciences Programs including Medical Assistant, Medical Administrative Assistant, Health Care Management, Massage Therapy, and Nursing; Exercise Science; and

WHEREAS, CLINIC has demonstrated its training capabilities suitable to the needs of the SCHOOL; and

WHEREAS, the parties need to define their respective rights and responsibilities;

NOW, THEREFORE, in consideration of the mutual undertakings and agreements hereinafter set forth, CLINIC, and the SCHOOL agree as follows:

1. TERM OF THE AGREEMENT

   This Agreement shall be for a period of five (5) years commencing on January 21, 2016 and terminating on January 20, 2021.

2. PROGRAM

   a. The parties mutually agree that CLINIC shall provide a program of clinical education for the SCHOOL's students. The educational program shall be devised jointly by the SCHOOL and CLINIC's Administrator, or his or her appointed agent or agents, in such a manner as they shall agree to be practical within the guidelines and restrictions established in this Agreement.

   b. Student/Trainee Participants (hereinafter called "students")

      (1) Selection: The selection of persons to participate in the program is at the joint discretion of the SCHOOL and CLINIC's Administrator or his or her appointed agent or agents, subject to the limitations set forth in this Agreement.

(2) Number: At any time during the term of this Agreement, the SCHOOL may send participants to CLINIC in such numbers as may be agreed upon from time to time by the SCHOOL and CLINIC's Administrator, or his or her appointed agent. The Administrator, or his or her agent, is expressly given power to limit the number of students accepted by CLINIC.

c. SCHOOL's Responsibilities

Faculty Supervisor: The SCHOOL shall appoint a faculty supervisor from its staff for all students participating in this program. The faculty supervisor has the primary responsibility of providing ongoing communication between CLINIC, as represented by CLINIC's Administrator or his or her appointed agent or agents, and the SCHOOL concerning the progress and problems of the program and the students involved in it.

Evaluation of the program and the students is the responsibility of the faculty supervisor. The CLINIC staff is expected to exercise its privilege of contributing comments and evaluations when pertinent to the improvement of the program and education of the students.

d. CLINIC Responsibilities

(1) CLINIC has ultimate responsibility for the quality of health care given to CLINIC patients. In order to effectively fulfill that duty, it is agreed that CLINIC has ultimate control over all persons involved in the program.

(2) In order to carry out its responsibilities under the Agreement, CLINIC shall provide clinical resources and facilities as it shall deem appropriate.

(3) The CLINIC will provide a written evaluation of the student's performance to the SCHOOL at the completion of the practicum experience.

(4) CLINIC will permit the SCHOOL faculty and students to have access to CLINIC patient medical records, as needed, pursuant to this Agreement and applicable CLINIC policies and procedure regarding protected health information.

(5) Emergency medical care is available at CLINIC for students. Students will be responsible for payment for all medical care charges.

e. Expenses

(1) All expenses incurred by students including, but not limited to, transportation, books and school supplies, shall be the responsibility of the person incurring the expense. CLINIC shall have no responsibility for such expenses.

(2) No student is an employee of the SCHOOL and no workers' compensation insurance to cover such students is required.

3. INDEMNIFICATION AND INSURANCE

a. Each party agrees that it will be responsible for its own acts and the results thereof, to the extent authorized by law and shall not be responsible for the acts of the other party and the results thereof.

b. The SCHOOL agrees to indemnify and save and hold CLINIC, its representatives and employees harmless from any and all claims or causes of action arising from the performance of this contract by the SCHOOL or the SCHOOL's agents or employees. Likewise, CLINIC agrees to indemnify and save and hold the SCHOOL, its representatives and employees harmless from any and all claims or causes of action arising from the performance of this contract by CLINIC or the CLINIC's agents or employees. Immunities above said limits are not waived.

c. In order to protect CLINIC and the SCHOOL and those persons and parties listed above, CLINIC and the SCHOOL agree that at all times during the term of this Agreement and beyond such term when requested, the SCHOOL will ensure no students or faculty shall commence work at the CLINIC facility unless covered by Malpractice insurance. The SCHOOL has obtained private group student intern malpractice insurance for SCHOOL students and faculty, with liability limits of $1,000,000 per occurrence / $3,000,000 annual aggregate.

A certificate of insurance for this policy is available from the SCHOOL and will be filed with CLINIC if CLINIC so instructs.

4. NON-DISCRIMINATION

The SCHOOL and CLINIC will comply with all applicable State and Federal laws and rules against discrimination.

5. INDEPENDENT CONTRACTOR

It is agreed that nothing herein contained is intended or should be construed in any manner as creating or establishing the relationship of co-partners between the parties hereto or as constituting the SCHOOL, its officers, agents, employees, or students, as the agent, representative, or employee of CLINIC for any purpose or in any manner whatsoever. The SCHOOL is to be and shall remain an independent contractor with respect to all services performed under this Agreement. The SCHOOL represents that it has, or will secure at its own expense, all personnel required in performing services under this Agreement. It is agreed that any and all personnel of the SCHOOL or other persons, including SCHOOL students, while engaged in the performance of any work or services required by the SCHOOL under this Agreement, shall have no contractual relationship with CLINIC and shall not be considered employees of CLINIC. Such personnel or other persons, including SCHOOL students, shall not require nor be entitled to any compensation, rights, or benefits of any kind whatsoever from CLINIC, including, without limitation, tenure rights, medical and hospital care, sick and vacation leave, Worker Compensation, Re-employment Compensation, disability, severance pay, tort liability indemnification, and PERA.

6. BACKGROUND CHECKS

The SCHOOL will ensure that criminal background checks have been completed for students prior to participating in clinical experience. Self-disclosure forms and criminal record checks will be kept on file by the SCHOOL. Upon request of the CLINIC such forms will be made available for review for the purpose of assuring compliance with legal and regulatory standards.

7. CANCELLATION

Either the SCHOOL or CLINIC's Administrator may cancel this entire Agreement or any portion thereof with or without cause upon ninety (90) days' written notice delivered by mail or in person; provided, however, that at the time notice is given, any students participating in the program shall be allowed to complete the quarter or semester in which they are enrolled.

**THIS PORTION OF PAGE INTENTIONALLY LEFT BLANK.**

8. NOTICES

Any notice or demand which must be given or made by a party hereto under the terms of this Agreement or any statute or ordinance shall be in writing, and shall be sent certified mail.

Notices to CLINIC shall be sent to:
Watertown Regional Medical Center
Attn: Shane Brown
125 Hospital Drive
Watertown, WI 53098

Notice to the SCHOOL shall be sent to:
Minnesota School of Business
Attn: Meredith Butulis
8089 Globe Drive
Woodbury, MN 55125
With a copy to:
Globe University/Minnesota School of Business
Attn: Ken McCarthy
8089 Globe Drive
Woodbury, MN 55125

9. HEALTH REQUIREMENTS FOR PERSONS WORKING IN PATIENT CARE AREAS

The SCHOOL shall verify that the all SCHOOL'S employees/students coming to CLINIC have been administered a Mantoux test and follow-up, as indicated, within six months (or one year if on a yearly testing program) prior to the employee's/student's start at CLINIC. Documentation shall be kept by SCHOOL at the SCHOOL site and available, if needed, for reference by CLINIC.

The SCHOOL is responsible for verifying that their employee/student has had Mumps, Rubella, Rubeola, Chickenpox and Hepatitis B screening and vaccination, as indicated. Documentation shall be kept by SCHOOL at the SCHOOL site and available, if needed, for reference by CLINIC.

SCHOOL'S employees/students with infectious diseases or any open or dripping lesions on their body must be evaluated in the CLINIC. CLINIC will determine their ability to participate in their duties and counsel the employee/student on precautions to prevent the spread of nosocomial disease.

10. ADA COMPLIANCE

CLINIC agrees that in fulfilling the duties of this Agreement, CLINIC is responsible for complying with the American with Disabilities Act and any regulations promulgated to the Act. The SCHOOL is not responsible for issues or challenges related to compliance with the ADA beyond its own routine use of facilities, services, or other services covered by the ADA.

11. FINANCIAL CONSIDERATIONS

a. The SCHOOL and CLINIC shall each bear their own costs associated with this Agreement and no payment is required by either the SCHOOL or CLINIC to the other party.

b. CLINIC is not required to reimburse the SCHOOL faculty or students for any services rendered to the Facility or its patients pursuant to this Agreement.

12. AMENDMENTS

Any amendment to this Agreement shall be in writing and signed by authorized officers of each party.

13. GOVERNING LAW

All questions concerning the construction, validity and interpretation of this Agreement, and the performance of the obligations imposed by this Agreement, shall be governed by the laws of the State of Minnesota without regard to any principles of conflicts of laws.

14. ENTIRE AGREEMENT

This Agreement constitutes the complete and entire agreement of the parties concerning the matters referred to in it, and supersedes all prior agreements and understandings, whether written or oral.

**THIS PORTION OF PAGE INTENTIONALLY LEFT BLANK.**

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement with the above terms and conditions by the signatures below.

WATERTOWN REGIONAL MEDICAL CENTER

By: _____

Title: CEO

Date: 2-18-16

The CLINIC certifies that the person who executed this Agreement is authorized to do so on behalf of the entity as required by applicable articles, bylaws, resolutions or ordinances.

GLOBE UNIVERSITY, INC.
MINNESOTA SCHOOL OF BUSINESS, INC.

By: _____

Title: CFO

Date: 2/23/16

The SCHOOL certifies that the person who executed this Agreement is authorized to do so on behalf of the entity as required by applicable articles, bylaws, resolutions or ordinances.

Watertown Regional Medical Center
Position Description/Performance Evaluation/Physical Requirements

| | | | |
|---|---|---|---|
| **Job Title:** | Staff Nurse | Position: | 01.4000.210<br>01.4000.213<br>01.4340.213 |
| **Department:** | Inpatient Center | **FLSA:** | Hourly, non-exempt |
| **Labor Grade:** | 310 or 311 | **OT option:** | ___8/80 ___40 |

___ **Additional Department Specific competencies must be attached for this job.**

**SUPERVISORY RELATIONSHIPS:**

**Reports to:** Director of IPC
Manager, IPC
**Supervises**: PCP, LPN, CNA, CA, NT's

**BASIC FUNCTION**:

The Staff Nurse is responsible to provide total nursing care of the patient, both direct and indirect, within an assigned patient care unit. This position carries out these responsibilities independently with the guidance of accepted nursing and department practice as well as directed by medical staff. This position provides the knowledge and skills to meet physician, patient, staff, and/or WRMC needs and performs in accordance with WRMC standards and policies.

1. Demonstrates an understanding of Watertown Regional Medical Center Mission Statement, Vision and Values as described in our Associate Handbook and our E3 Associate Guide to Success by:
2. Displaying a positive attitude and providing solutions, (not complaints), giving others the benefit of the doubt, and avoiding negativity.
3. Assuming a sense of ownership by, staying informed, taking initiative to provide excellence with every encounter, and receiving criticism with a smile.
4. Demonstrating excellent communication abilities by asking questions, providing suggestions, thanking others and solving disagreements-face to face, in a polite and respectful manner, and by consistently applying the AIDET methods.
5. Promoting exceptional teamwork, by working across departmental lines to serve our patients and guests, and by working tirelessly to maintain quality working relationships with coworkers, other departments and with the Medical Staff.
6. Displaying an ability to provide assistance, or care, appropriate for the ages and developmental needs, of patients and other individuals served, while performing the duties of the job.
7. Performing all position duties and responsibilities in accordance with standards of Joint Commission and WRMC's performance evaluation and competency assessment policies.
8. Performs all position duties and responsibilities in accordance with accepted nursing and department practice.
9 Works to establish good relationships with other team members.
10. Utilizes available WRMC resources as necessary to provide for continuity of patient care.
11. Communicates clearly and effectively with all customers.
12. Carries out safety and infection control procedures to insure patient, staff and visitor safety.
13. Makes initial and continued assessment of patients' physical, psychological, and spiritual needs.
14. Participates with the multidisciplinary team in discharge planning.

15. Plans nursing care with patient including formulating goals for nursing care, prescribing nursing actions to achieve these goals, and using priorities for nursing actions.
16. Evaluates symptoms, reactions, and progress of patient assigned. Observes, records and reports such to appropriate team members.
17. Will maintain competency in admission/discharge, provision of nursing care, documentation and rhythm interpretation for telemetry patients.
18. Incorporates patient and family teaching to nursing care. Educates patients and significant others about hospitalization disease process, discharge care, and follow-up.
19. Responsible for direct patient care of assigned number of patients and organizes assignments and work area appropriately.
20. Incorporates knowledge of growth and development in order to provide appropriate care to population served.
21. Maintains strict confidentiality.
22. Maintains professional growth and development through attendance of seminars, workshops and professional affiliations.
23. Regular, predictable and dependable attendance.

If noted above, additional Department Specific Competencies must be attached to this form.

**OTHER DUTIES**:

1. Performs additional job related duties as assigned.
2. Serves on WRMC committees or task forces as requested.
3. Able to recognize life threatening arrhythmia's.
4. Able to perform basic operations of Lifeline.
5. Demonstrates knowledge in caring for patients receiving dialysis.
6. Able to identify normal and abnormal breath sounds
7. Demonstrates knowledge in the care for clients in Respite care.
8. Demonstrates knowledge in the care for patients in a swingbed.
9. Demonstrates knowledge in oxygen therapy, incentive spirometry and pulse oximetry.
10. Able to provide care to patients with tracheotomies.
11. Able to use doppler to assess pulses.

**POSITION QUALIFICATIONS**:

Education: Associate's Degree, Diploma, in Nursing or BSN.

Experience: None

Certification/License: Licensed by the State Board of Nursing as a Registered Nurse,
BLS provider required,
ACLS training preferred

Knowledge/Skills: Knowledge of healthcare delivery systems and its impact on clinical practice.
Knowledge of the interface effects with other healthcare disciplines and systems.
Provides, manages, integrates, and coordinates health prevention, protection, illness prevention, restoration, rehabilitation, and palliative care for patients.
Relates to patients, physicians and peers to develop and maintain effective work/patient relationships.
Applies critical thinking, analytical and participative behavior to solving techniques and decision making.
Operates mechanical equipment and expands knowledge through keeping up with advanced technology.
Initiates work assignments independently without specific direction.
Demonstrates responsibility and accountability according to legal, ethical, professional, educational, and personal development goals.
Prioritizes work and meets changing demands and deadlines.
Makes oral presentations including speaking to sizable groups.
Effective communication and interpersonal skills and behaviors.
Follow procedures related to position accountabilities.
Updates and develops continuous skills to provide care to the changing patient population providing for their growth and developmental needs.
Knowledge of WRMC safety and infection control procedures.
Knowledge and skills to provide care appropriate to the ages of patients served.
Knowledge and skills to provide care to patients in accordance with their developmental needs.
Learns and applies analytical and participative problem solving techniques.
Knowledge of basic aseptic techniques.
Knowledge of blood borne pathogens.

The above statements are intended to describe the general nature and level of work being performed by most people assigned to this job. They are not intended to be an exhaustive list of all responsibilities, duties, and requirements.

Watertown Regional Medical Center
Position Description/Performance Evaluation/Physical Requirements

Department #: 1.4000 Department Name: 3N INPATIENT CNTR Review Date: _____
Job #: Job Name: REGISTERED NURSE Manager/Director:

Use the letters below to indicate in each space the extent of time required for this position: Leave blank if not applicable.

| | | | |
|---|---|---|---|
| R - Rarely | 1-6% of the work shift | F - Frequently | 34%-66% of the work shift |
| O - Occasionally | 7% to 33% of the work shift | C - Constantly | 67%-100% of the work shift |

**A. Essential Physical Demands**

1. ___C___ Standing
2. ___C___ Walking
3. ___O___ Sitting
4. ___F___ Lifting floor to waist. Maximum of __50_____lbs.
5. ___F___ Lifting waist to shoulder. Maximum of __50___lbs.
6. ___O___ Carrying. Maximum of __24_____lbs.
7. ___O___ Pushing. Maximum of __250_____lbs.
8. ___O___ Pulling. Maximum of ___250_____lbs.
9. ___--___ Stair climbing.
10. __--___ Ladder climbing.
11. __R____ Balancing.
12. __O____ Sustained crouching.
13. __R____ Kneeling.
14. __F____ Repeated forward bending (i.e. to work over a patient or machine).
15. __F____ Repeated squatting (to the floor).
16. __--____ Crawling.
17. __F____ Reaching.
18. __O____ Elevated work.
19. __F____ Hand Manipulation
20. _____ Oral Communication. Speaks clearly. Spanish-English
21. _____ Hearing-Conversation
22. _____ Specific visual requirements: Near/Far
23. _____ Depth perception: (Y/N)
24. _____ Color Vision: Distinguish basic shades (Y/N)
25. _____ Color Vision: Distinguish basic colors (Y/N)
26. _____ Operation of truck or motor vehicle
27. _____ Other_____

**B. Working Conditions**

1. _____ Outside
2. _____ Outside and Inside
3. _____ Heat over 90 degrees
4. _____ Cold below 55 degrees
5. _____ Temperature changes –excessive/frequent
6. _____ Confined Spaces
7. _____ Heights
8. _____ Constant Noise above 85 dec.
9. _____ Intermittent Noise above 85 dec.
10. _____ Vibrations
11. _____ Exposure to Blood
12. _____ Fumes: Irritant—Toxic (circle one)
13. _____ Dust
14. _____ Gases: Type_____
15. _____ Lead
16. _____ Silica—Asbestos
17. _____ Chemicals: Types_____
18. _____ Greases and Oils: Types_____
19. _____ Latex
20. _____ Work with machinery having moving parts
21. _____ Work below ground
22. _____ Working with hands in water.
23. _____ Working alone
24. _____ Other_____

**C. PROTECTIVE EQUIPMENT REQUIRED**

1. _____ Respirator—Type
2. _____ Eye Protection –Type
3. _____ Hearing Protection –Type
4. _____ Hard Hat
5. _____ Gloves—Type
6. _____ Boots—Type
7. _____ Body Protection—Type
8. _____ Other_____

Watertown Regional Medical Center
Position Description/Performance Evaluation/Physical Requirements

***Section I:*** ***For all newly hired associates: Manager/Director please review position description/evaluation form, including competencies, with new associate, sign last page, have the new associate sign and return to Human Resources.***

***Section II:*** ***For 3-month evaluation: Manager/Director please review and rate each competency based on definitions included in the policy. Count the total number of occurrences for each category and record in section IV, below. Review this form with the associate, sign and date, have associate sign and date, and return this form to Human Resources within 30 days of Eval date indicated at the top of the form. An associate that "does not meet" a competency can not perform that competency. Probationary period may be extended up to 45 days, if all competencies are not met. All competencies must be met by the end of the probationary period.***

***Section III:*** ***For annual evaluation: Manager/Director please review and rate each competency based on definitions included in the policy. Count the total number of occurrences for each category and record in section IV, below. Review this form with the associate, sign and date, have associate sign and date, and return this form to Human Resources within 30 days of Eval date indicated at the top of the form. Associate's overall performance will be rated based on where most occurrences are noted. An associate that "does not meet" any competency can not perform that competency.***

***Section IV: Please total the number of occurrences for each of the following categories: Does not meet_____, Meets_____, Exceeds_____.***

***Section V:*** ***Please complete the following section for associates receiving annual evaluation:***

***(a) Annual Associate Health work: □ complete □ not complete (b) Annual Education Requirements: □ complete □ not complete***
***(c) Compliance to Attendance policy □ meets□ does not meet (d) Licensing/credentialing/certifications □ complete □ not complete***

*Manager: Please add any comments (Accomplishments, Improvements made, Areas requiring further improvement, goals and objectives for the next year).*

***Associate:*** ***Please add any comments:***

***Section VI: complete this signature section for all uses of this form and forward to Human Resources.***

**Associate** _____ **Date** _____ **Manager/Director** _____ **Date** _____

*Please consider the completion of this form a review of performance for the specific period of time. Consistent and ongoing interaction between each associate and their immediate supervisor is an expectation of all supervisory positions at Watertown Regional Medical Center.*

**Program evaluation plan for Globe University- Madison East BSN Program**

The program evaluation plan for Globe University Madison East campus would include the following items, which are facilitated continually in efforts for exemplary outcomes:

- NCLEX
    - Students in the Globe University nursing program will begin NCLEX preparations starting with their first day of class and last through the end of the program. Assessment Technology Institute (ATI) is incorporated throughout the nursing curriculum. After graduation, students are paired with an ATI virtual tutor for final preparations for the NCLEX. The virtual ATI tutor is a proven 12 week NCLEX preparation review. Students who participate in the VATI and receive the green light to take NCLEX have a proven higher NCLEX pass rate than the national average.
    - NCLEX pass rates will be evaluated. The goal would be to be above 80% success rate on first time NCLEX test takers. The nursing program will reach out to students who did not pass on the first attempt to discuss if there were deviations among their test-preparation process, and what assistance they might offer
- Career Assistance
    - The career services department will keep track of job assistance/placement with nursing graduates with a goal of a placement rate of 75% a year.
    - The program chair of the nursing program will work in conjunction with the dedicated team of career services professionals at the campus to provide the best assistance to the student. This will include providing mock interviews, assistance with resume building, and discussions on what type of employment they are seeking
- Faculty Evaluations
    - Nursing instructors will have the following completed on an annual basis:
        - Professional Development
        - Continuing education
        - Performance appraisal
        - Background study
    - Nursing faculty will meet and collaboratively work with the campus dean of faculty to discuss how their professional development plans can be enhanced, the purpose they serve, and how to reach professional objectives
    - Nursing instructors will have the following completed on a quarterly basis:
        - Classroom/lab/clinical observations
        - Quarterly performance evaluation
- Nursing Program Evaluation
    - The campus will host an annual Nursing Forum. This forum is a mandatory event for all nursing student that serves as an opportunity for professional development. During this forum various educational topics will be discussed, the job outlook will be outlined and alumni will serve as a panel for student questions. Additionally, students will complete annual surveys. The survey will ask the following questions, using a Likert scale for measurement:
        - I am aware of the ten expected program outcomes and their link to the Essentials of Baccalaureate Education and my role preparation as a professional nurse.
        - I am satisfied that the nursing curriculum is assisting me to understand/develop my role as a baccalaureate prepared nurse.

        - I value the learning experiences in course content and recognize their usefulness in preparing me for the professional nursing role.
          I apply learning gained from general education courses to nursing content and patient care.
        - I am satisfied with the overall quality of the nursing program.
        - I am satisfied with eh leadership of the program
        - I am satisfied with the effectiveness of clinical experiences throughout the program.
        - I am satisfied with the simulation and lab components of the nursing courses as a learning environment.
          I am satisfied with the overall quality of instruction by faculty across the curriculum.
        - I feel my input and comments are values as a student in the nursing program.
        - The procedural polices of the program are clearly stated and accessible.
    - The following three questions will be given to students within the survey for completion:
        - From your perspective, please identify the areas of greatest program strength.
        - From your perspective, please identify the areas of the program that most needs evaluation and ongoing improvements.
        - Do you have any other comments, questions, or concerns you would like to share with the nursing leadership team?
    - After surveys are collected and analyzed by the Dean of Nursing, it will be sent to the leadership team as well as the Program Advisory Committee (PAC) for review and any actions moving forward.
- Learner Outcome Assessments
  The purpose of LOAs at our Madison campus is to ensure our students are acquiring essential knowledge, skills, and abilities so that they will be successful in their career as a professional nurse. Below is the list of LOAs, which class they are associated with, and how they are measured.

| # | LOA | Course Associated | Assessment Assignment |
|---|---|---|---|
| 1 | Use knowledge of human diversity, global health care and information technology to promote the health care of individuals across the lifespan | RN156 Health Promotion Across the Lifespan | Reflection paper on "A Framework for Understanding Poverty", correlating content with applicability to nursing practice. |
| 2 | Integrate nursing knowledge with the humanities, arts and sciences to provide holistic care within the practice of professional nursing | RN303 Family Health in Nursing | Evaluation of family values and interactions essay/term paper |
| 3 | Demonstrate effective critical thinking, communication, assessment, and | RN206 Holistic Health Assessment | Client health history and assessment |

| | | | |
|---|---|---|---|
| | technical skills in the practice of professional nursing | | |
| 4 | Collaborate with patients, healthcare providers and other members of the interdisciplinary team to assess, plan, implement and evaluate patient focused outcomes | RN413 Nursing Internship/Professional Role Development | Participate in intra and interprofessional collaboration care/discussions/meetings focused on improving patient outcomes. Write a reflection paper analyzing the student's role within the collaborative process and correlate to patient outcomes. |
| 5 | Advocate for the patients and consumers of health care within health care delivery systems | RN404 Holistic End of Life Care | Analyze a patient/family assessment at end of life and facilitate measures to meet patient wishes. |
| 6 | Use knowledge of health promotion, risk reduction and disease prevention in providing holistic care to individuals, families, groups and communities | RN408 Community Health in Nursing | Conduct a community assessment: identify health problems within individuals, families or groups of the community and design a health program aimed at promoting health or risk reduction. |
| 7 | Apply research-based knowledge from nursing and the sciences as a foundation for evidenced based practice in maintaining, restoring and optimizing health | RN403 Nursing Research and Evidence Based Practice | Research for evidence in a topic related to patient care and correlate it to current practice standards. |
| 8 | Demonstrate values and ethical behaviors reflective of professional nursing practice | RN304 Healthcare Issues Across the Lifespan | Research social justice as it relates to values and ethics within nursing practice. Correlate qualities of a nurse in relationship to social justice. |
| 9 | Demonstrate self-awareness in identifying goals for life-long professional development | RN413 Nursing Internship/ Professional Role Development | Scholarly paper showing evidence of attaining program expected outcomes and a plan for professional development related to capstone clinical internship experience (CIE). |

| | | | |
|---|---|---|---|
| 10 | Incorporate leadership skills into the practice of professional nursing | RN405 Leadership and Management in Nursing | Leadership Project: Identify an organizational need within a facility and develop a plan to meet the need. Reflection regarding leadership as a component of life-long learning included in analysis. |

- Program Advisory Committee
  - A Program Advisory Committee (PAC) is comprised of leaders within the nursing community and will have an annual meeting to evaluate the BSN program at Globe University. At this time, we have six community professional nurses who have agreed to be a part of the Globe University Program Advisory Committee.

| | | | |
|---|---|---|---|
| Elizabeth Fritz | Madison-East | Elizabeth.Fritz@deancare.com | Dean Clinical nurse educator |
| Kate Piotrzkowski | Madison-East | Kate.Piotrzkowski@deancare.com | Dean Clinical Nurse Educator |
| Joy Pfeffer | Madison-East | Joyanne.Pfeffer@SaukPraiireHealthcare.org | Sauk Praire Health Care Staff Education Coordinator |
| Olivia Schroeder | Madison-East | olivialschroeder@gmail.com | WI Nurse Association |
| Kimberly Kenney | Madison-East | kimkrnmsn@gmail.com | UofW Hospital |
| Suzanne Hoffman | Madison-East | Sznn.mntg@gmail.com | Meriter-Unity Point Health |

**Simulation Training**
**Globe University**
**Madison, Wisconsin**

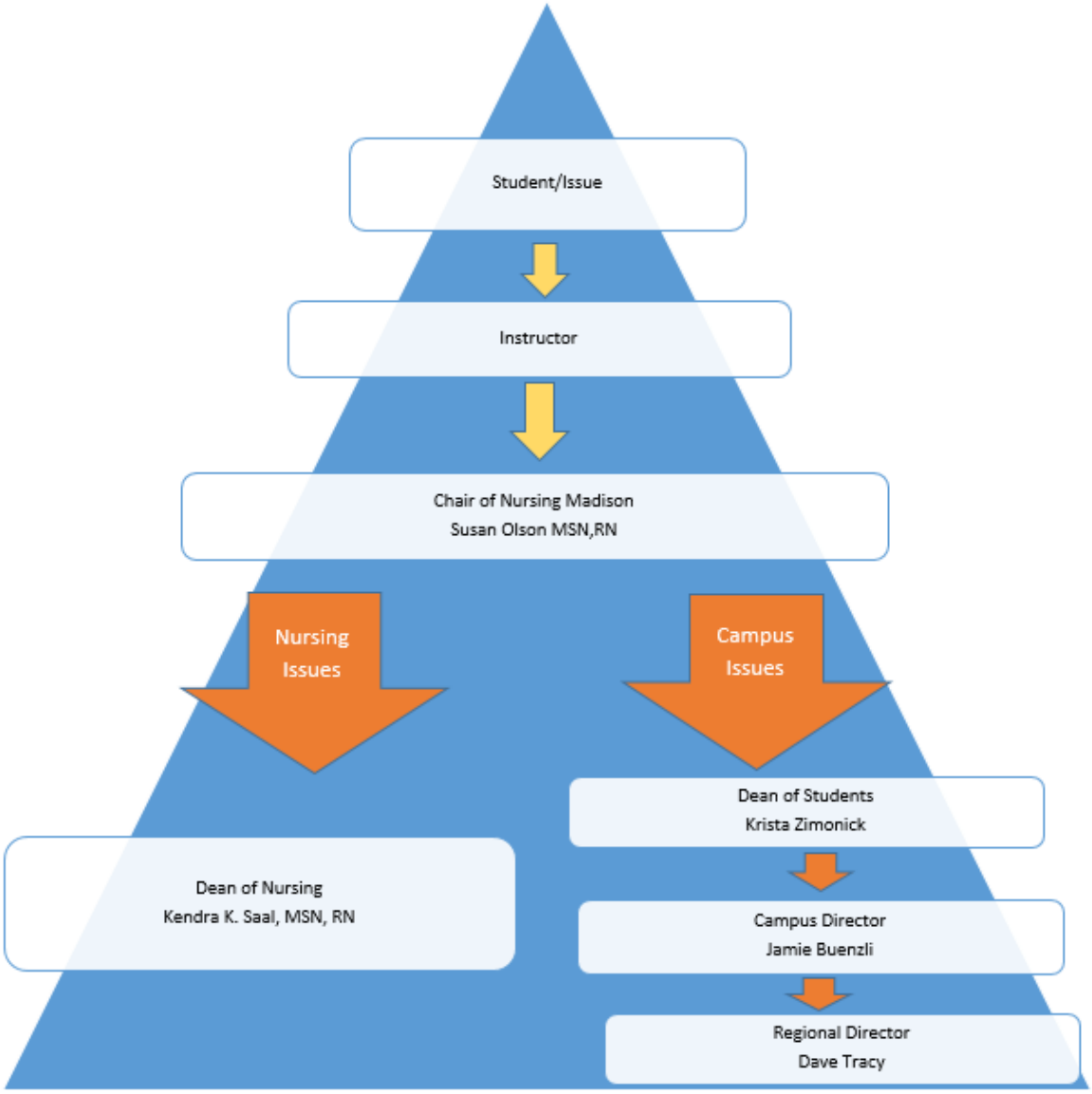
*"Tell me, and I will forget. Show me, and I may remember. Involve me, and I will understand."* — Chinese Proverb

Globe University Baccalaureate of Science in Nursing (BSN) believes in the value of properly-run simulation to enhance the learning of the developing nursing student. We agree with the NCSBN in that simulation is an, "Innovative teaching strategy that complements clinical experiences for entry into practice competency." Strategies that will be taken to ensure that there is excellent in simulation include the following:

- Full time simulation and lab nursing staff
- Membership in the International Nursing Association for Clinical Simulation and Learning (INACSL)
    - Benefits of being a member of INACSL
        - Part of a list-serve to deepen conversations and learning related to simulation
        - Sharing of key learning documents
        - Webinars
        - Newsletters
        - Annual Meeting
        - Peer review journals
- Networking with other college and universities
- Annual HPSN World conference
    - Goal of HPSN World Conference is to "deploy deliberate practice to improve our technical skills as well as interprofessional communication."

**Globe University**
**Madison, Wisconsin**
**Plan for Chain of Command**

Globe University - Madison East campus Baccalaureate of Science in Nursing (BSN) will share a Nursing Dean, Ms. Kendra Saal with Minnesota School of Business - Richfield. While the campuses are four hours apart in distance, Ms. Saal will be able to oversee both programs with the assistance of a program chair at both campuses (Ms. Susan Coleman - Madison East and Ms. Janet Rounsville - Richfield). Ms. Saal will be traveling between both campuses and will facilitate weekly communication updates between both campuses. Below is the organization chart for the Madison-East campus.



# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| | |
|---|---|
| 1) Name and Title of Person Submitting the Request:<br><br>**Dan Williams**<br>**Executive Director** | 2) Date When Request Submitted:<br><br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |

3) Name of Board, Committee, Council, Sections:

**Board of Nursing**

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **8 September 2016** | ☐ Yes<br>☐ No | **Education Matters – Discussion and Consideration**<br>**1. Education Liaison verbal update as to ACEN action for Herzing University – Madison** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☐ Yes (Fill out Board Appearance Request)<br>☐ No | |

10) Describe the issue and action that should be addressed:

11) Authorization

*Sharon Henes* — *26 August 2016*

Signature of person making this request — Date

Supervisor (if required) — Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — Date

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

*Revised 8/13*

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| | |
|---|---|
| 1) Name and Title of Person Submitting the Request:<br><br>**Sharon Henes**<br>**Administrative Rules Coordinator** | 2) Date When Request Submitted:<br><br>**26 August 2016**<br><br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |

3) Name of Board, Committee, Council, Sections:

**Board of Nursing**

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **8 September 2016** | ☐ Yes<br>☐ No | **Education Matters – Discussion and Consideration**<br>**1. Site Survey Report and NCLEX Plan for Herzing University – Kenosha/Brookfield** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☐ Yes (Fill out Board Appearance Request)<br>☐ No | |

10) Describe the issue and action that should be addressed:

11) Authorization

*Sharon Henes* — *26 August 2016*

Signature of person making this request — Date

Supervisor (if required) — Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — Date

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

*Revised 8/13*

# Wisconsin Department of Safety and Professional Services

**Mail To: P.O. Box 8935**
**Madison, WI 53708-8935**

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 266-2264
**Phone #: (608) 266-2112**

E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov


## BOARD OF NURSING

NURSING PROGRAM SURVEY REPORT

**Directions for completing the Survey Report:** The following list of standards from N 1.08 will be used by the Board representative(s) when conducting a survey to ensure school compliance. The Board representative(s) should indicate whether the nursing school complies with Board standards by writing "yes", "no", "unclear", or "NA" (not applicable) on the line next to each requirement. On an attached document the Board representative(s) should provide the following:

- A description of why the nursing school does not meet Board standards for each "no."
- The additional information required to make a determination for each "unclear."
- A description of why this rule does not apply to the nursing program for each "NA."

**Institution being surveyed:**

Name of School: Herzing University - Kenosha

Address: 4006 Washington Road, Kenosha, WI 53144

Program (ADN, BSN, Other): BSN

**N 1.08 (1) ORGANIZATION AND ADMINISTRATION**

1. _Unclear_ The nursing school has a governing institution that assumes legal responsibility for the overall conduct of the school.

2. __Yes___ The governing institution has designated an educational administrator meeting the qualifications in N 1.08 (2)(a).

3. __Yes___ The governing institution has established administrative policies.

4. _Unclear_ The governing institution has provided fiscal, human, physical, clinical and technical learning resources adequate to support school processes, security, and outcomes.

5. __Yes___ The governing institution has evidence of being regionally accredited.

6. __Yes___ The governing institution has developed and maintained written school of nursing administrative policies which are in accord with the institution.
*Note: The Board representative(s) may examine the administrative policies during the survey to ensure that Board standards are being met.*




**Committed to Equal Opportunity in Employment and Licensing**

7. __Yes___ The governing institution has written contracts between the school of nursing and institutions which offer associated academic study, clinical facilities, and agencies for related services for students.
*Note: The Board representative(s) may examine the contracts between the school and institutions during the survey.*

**N 1.08 (3) FACULTY**

*Note: Chapter N 1.08 (3)(a) requires the nursing program to file evidence of meeting faculty standards in the School of Nursing office and make available to the Board upon request. The Board representative(s) will review Form #1114 for each faculty member.*

8. __Yes___ The faculty are adequate in number and academic and professional qualifications for the number and size of classes admitted annually, and the clinical facilities used in the program.

9. __Yes___ All nurse faculty members who teach in a professional nursing program hold a current, active license or privilege to practice as a registered nurse in Wisconsin that is not encumbered, and hold a graduate degree with a major in nursing.

10. ___N/A_ All nurse faculty members who teach in a practical nursing program hold a current, active license or privilege to practice as a registered nurse in Wisconsin that is not encumbered, and hold a baccalaureate degree with a major in nursing.

11. _____ The school has been granted ___0___ faculty exceptions to the faculty requirements.
List exceptions held: _____
*Note: The Board representative(s) will review to ensure faculty exception qualifications are met.*

12. ___Yes_ The educational administrator has taken responsibility for ensuring that individual faculty members are academically and professionally qualified, and that faculty staff is adequate to carry out program objectives.

**N 1.08 (4) CURRICULUM**

13. __Yes___ Curriculum enables the student to develop the nursing knowledge, skills and abilities necessary for the level, scope and standards of competent nursing practice expected at the level of licensure.

14. ___No___ Curriculum is developed by a faculty member with a graduate degree.

15. __Yes___ Curriculum is revised as necessary to maintain a program that reflects advances in health care and its delivery.

16. __Yes___ Curriculum includes evidence-based learning experiences and methods of instruction consistent with the written curriculum plan. The methods of instruction may include distance education methods.

17. __Yes___ Curriculum includes diverse didactic and clinical learning experiences consistent with program outcomes.

18. __Yes___ Coursework includes content in the biological, physical, social and behavioral sciences to provide a foundation for safe and effective nursing practice.

19. __Yes___ Coursework includes content regarding professional responsibilities, legal and ethical issues, and history and trends in nursing and health care.

20. __Yes___ Course work includes didactic content and supervised clinical experiences in the prevention of illness and the promotion, restoration and maintenance of health in patients across the lifespan and from diverse cultural, ethnic, social and economic backgrounds.

**N 1.08 (5) CLINICAL LEARNING EXPERIENCES**

21. __Yes___ Patient experiences occur in a variety of clinical or simulated settings.

22. __Yes___ Clinical learning experience includes integrating patient safety principles throughout the didactic and clinical coursework.

23. __Yes___ Clinical learning experience includes implementing evidence-based practice to integrate best research with clinical expertise and patient values for optimal care, including skills to identify and apply best practices to nursing care.

24. __Yes___ Clinical learning experience provides patient-centered culturally competent care that recognizes that the patient or designee is the source of control and full partner in providing coordinated care by doing the following:
(a) Respecting patient differences, values, preferences, and expressed needs.
(b) Involving patients or designees in decision-making and care management.
(c) Coordinating and managing patient care across settings.
(d) Explaining appropriate and accessible interventions to patients and populations that may positively affect their ability to achieve healthy lifestyles.

25. __Yes___ Clinical learning experience includes collaborating with interprofessional teams to foster open communication, mutual respect, and shared decision-making in order to achieve quality patient care.

26. __Yes___ Clinical learning experience includes participating in quality improvement processes to monitor patient care outcomes, identify possibility of hazards and errors and collaborate in the development and testing of changes that improve the quality and safety of health care systems.

27. __Yes___ Clinical learning experience includes using information technology to communicate, mitigate errors, and support decision-making.

28. __Yes___ All cooperating agencies selected for clinical experiences shall have standards which demonstrate concern for the patient and evidence the skillful application of all measures of safe nursing practices.

29. ___No___ All faculty teaching clinical or practicum courses are experienced in the clinical area of the course and maintain clinical expertise.

30. __Yes___ Faculty-supervised clinical practice includes: development of skills in direct patient care; making clinical judgments; care and management of both individuals and groups of patients across the lifespan; and delegation to and supervision of other health care providers.

31. ___No___ Clinical experiences are supervised by qualified faculty.

32. __Yes___ All student clinical experiences, including those with preceptors are directed by nursing faculty.

**N 1.08 (6) CLINICAL LEARNING EXPERIENCES**

33. __Yes___ Preceptors are approved by the faculty of the school of nursing.

34. __Yes___ The school of nursing provides each preceptor with an orientation concerning the roles and responsibilities of the students, faculty and preceptors.

35. __Yes___ The preceptors has clearly documented roles and responsibilities.
*Note: The Board representative(s) may examine the roles and responsibilities document.*

36. __Yes___ All clinical preceptors have an unencumbered license or privilege to practice in Wisconsin as a nurse at or above the licensure level for which the student is being prepared.
*Note: The Board representative(s) may examine documentation of all preceptors.*

37. __Yes___ Preceptors demonstrate competencies related to the area of assigned clinical teaching responsibilities.

**N 1.08 (7) EVALUATION**

33. _Unclear_ The school of nursing implements a comprehensive, systematic plan for ongoing evaluation. Evidence of implementation shall reflect progress toward or achievement of program outcomes.

**SITES VISITED DURING SURVEY:** (*Site Name, Address*)

Herzing University

4006 Washington Road

Kenosha, WI

Aurora Medical Center

10400 75th Street

Kenosha, WI

**SURVEY COMPLETED BY:**

Joan Gage
Name

Education and Licensing Program Manager
Title

/s/ Joan Gage
Signature

August 30, 2016
Date

Sharon Henes
Name

Administrative Rules Coordinator
Title

/s/ Sharon Henes
Signature

August 30, 2016
Date

Peter Kallio
Name

Board Member
Title

/s/ Peter Kallio
Signature

August 30, 2016
Date

Sheryl Krause
Name

Board Vice Chair
Title

/s/ Sheryl Krause
Signature

August 30, 2016
Date

**SURVEY NOTES**

Please provide the following: **(1)** A description of why the nursing program does not meet Board standards for each "no" in this report; **(2)** The additional information required to make a determination for each "unclear" in this report; and, **(3)** A description of why this rule does not apply to the nursing program for each "NA" in this report. Attach additional pages as needed.

1. Based upon interviews with faculty and review of documents, including policies, the governing institution that assumes legal responsibility for the overall conduct of the school is unclear. While the most recent organizational chart indicates the legal responsibility is with the Kenosha Campus, the March 2016 submission to the Board and discussions with faculty and the provided policies indicate that Academic Deans and Campus Presidents have the authority over their individual campuses (Brookfield Campus and Kenosha Campus) and that the Nursing School is not clearly aligned with either campus as the governing institution.

4. It is unclear whether the governing institution has provided human and clinical learning resources adequate to support school outcomes. There was a concern relating to simulation experience being provided to the students. One campus had a vacancy related to the simulation experience and the other campus did not have a person who was adequately trained for providing simulation experiences.

14. Curriculum is not developed by a faculty member.

29. Faculty teaching the simulation clinical learning experiences did not demonstrate clinical expertise. Faculty did not have experience in acute care.

31. Simulation clinical experiences are not supervised by qualified faculty.

33. It is unclear whether there is a comprehensive, systematic plan for ongoing evaluation.

There currently is a new plan for improvement of NCLEX pass rates which will be submitted to the Board of Nursing at the September meeting.

555 S. Executive Drive, Brookfield, WI 53005

**HERZING BROOKFIELD-KENOSHA PRE-LICENSURE NURSING PROGRAM PLAN**

**August 26, 2016**

TO: Mr. Dan Williams, Executive Director, Wisconsin Board of Nursing
Mr. Jeffrey G. Miller, DNP, MSN, RNCS, APNP, ACRN Chairperson, Wisconsin Board of Nursing

FROM: Deborah J. Ziebarth, PhD, MSN Ed, RN-BC, Department Chair of Nursing

Herzing University has worked closely with the Board of Nursing to develop a plan that will facilitate achievement of the BON compliance thresholds by graduates from the pre-licensure nursing program at the Brookfield/Kenosha campus. The recent probability ATI indicator scores for the eighth (final) semester students demonstrate that 80% of the students have achieved a score of 90% or better, indicating probable success on the NCLEX. Although this data is encouraging, the following plan has been developed to explicitly address the historically low NCLEX first time pass rates for the program. The plan to improve NCLEX pass rates requires attention to four areas, which are based upon the recommendations received from the Board of Nursing during the July, 18, 2016 site visit:

1. Organizational Structure;
2. Students;
3. Faculty; and
4. Curriculum.

The following plan addresses each of four areas as well as operational process changes being implemented in the program. It is the belief of the faculty and administration that this detailed plan--and iterative monitoring of the plan--provides a strong infrastructure for faculty and students to demonstrate compliance with the BON threshold scores in 2016.
Kind Regards,

*Dr. Deborah Ziebarth*

Dr. D. Ziebarth, PhD, MSN Ed, RN-BC, Department Chair of Nursing
Herzing University
Nursing Department Chair
Brookfield/Kenosha Campuses
555 Executive Drive, Brookfield, Wisconsin, 53005
dziebarth@herzing.edu
Work: 262-649-1710
Cell: 414-3155456

HERZING UNIVERSITY
555 S. Executive Drive, Brookfield, WI 53005

**Herzing University Plan for graduates from the pre-licensure nursing program at the Brookfield/Kenosha campus**.

| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| **ORGANIZATIONAL** | | | |
| **A.** Suspension of admissions to BSN program. | July 2016 | Admissions data as collected on the Master Student Listing by the Student Information System. | Suspension of admissions effective July 2016. Will revisit this action in November 2016. |
| B. Elimination of conditionally admitted nursing students. | May 2016 | No conditionally admitted students. | No conditionally admitted students as of May 2016. |
| C. Transition to a new Nursing Administrative structure for the Brookfield/Kenosha program. | June 2016<br><br>May 2016 | "Interim" Department Chair hired and transitioned into permanent Department Chair position.<br><br>One Program Chair to be hired to provide oversight of the nursing program at each site.<br>*See Appendix I: Organizational Chart | June 2016 – Completed<br><br>This objective is partially met with one Program Chair in place for Kenosha - May 2016. |
| D. Engagement of dedicated mentor to support Department Chair. | June 2016 | Plan collaboratively developed by mentor and Department Chair. | Mentored contracted to provide support (in-person, email, and telephone). |
| E. Exploration of feasibility of separating the Brookfield/Kenosha program into two separate entities. | August 2016 | Task Force formed to investigate feasibility.<br>Task Force members: Renee | In Process.<br>• Accreditation: Initial conversation with CCNE occurred July 2016. |

| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| (WBON suggestion at site visit 8/2016) | | Herzing, President of Herzing University; Dr. Kautzer, Provost; Dr. Edwards, Director of Nursing Accreditation and Regulatory Affairs; Dr. Ziebarth, Nursing Department Chair at Kenosha/ Brookfield Campuses; Beth Gilbertson, Academic Dean at Kenosha Campus, Steve McAvoy, Academic Dean at Brookfield Campus; Jeff Hill, President at Kenosha Campus; and Jarvis Racine, President at Brookfield Campus. | • WBON: Preference for main and branch campuses verified on August 2016.<br>• Task TimeLine development in process. |
| **STUDENTS** | | | |
| A. Revised Student-Focused NCLEX Preparation Plan | | | |
| • Introduced ATI Capstone into NU 447. Initiated ATI Live (Spring-2013), Predictor/ Probability Scoring (Spring-2013), and Virtual ATI (Spring-2015). | January 2016. | • Student attendance NU447<br>• 8th semester predictor/probability scores (as a result of ATI Capstone integration into NU 447).<br>• See Appendix II: NU 447 Syllabus | As of January 2016, this objective has been met with 100% participation.<br>(Spring 2016: N=11)<br>(Summer 2016: N=30)<br>Predictor/Probability scores: 80% of 8th semester students are at or above 90%. |
| • Individualized "NCLEX study plans" developed. | August | Students (8th semester) and contracted "Student Advisor" review | This objective has been met- August 2016 (N=30). |

| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| | 2016 | Predictor/Probability scores and create individualized "NCLEX study plans" developed during 1:1 meetings.<br>*See Appendix III: Example of a Study Plan | |
| • Engaged Student Advisor" (MSN-RN) to assist with development of individualized "NCLEX study plans" for all levels of BSN nursing students. | August 2016 | Student's individualized NCLEX study plan development (100%) | ATI specialist contracted to temporarily serve in "advisor role" to help 8th semester students develop NCLEX study plans and monitor compliance.<br><br>August 2016 N= 30 (100%) 8th semester students have developed plans based on predictive/probability scores.<br><br>New student advisor role will be filled by a permanent RN-MSN staff position to assist all students in the program to develop NCLEX study plans and to monitor compliance with plans. Job description has been created and position posted. Projected to be filled by January 2017. |
| B. Optimize implementation of the STAR (SUCCESS | May 2016, revised | Drive awareness of the STAR Program | Students enrolled since August 2016 (N= 66). |

| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| THROUGH ACADEMIC RETENTION) Program. **This program provides professional role models by linking students enrolled in the nursing program with nursing faculty members.* | August 2016 | • Posters displayed at both campuses<br>• BB announcements<br>• Agenda item at faculty and students meetings<br>• Mass emails | • Students self-enrolled:31<br>• Students enrolled through referrals: 35 |
| C. Hire nursing program tutor. | January 2016 | In-house tutor hired to meet needs of nursing students.<br>*See Appendix IV: Tutor Schedule | Nursing tutor hired and weekly schedule increased from 12 to 16 hours. |
| D. Require NCLEX Prep Classes as mandatory for students in the 6Th (NU010) & 7th (NU011) semesters. | January 2016, revised August 2016 | Course attendance at non-credit scheduled NCLEX Prep Classes (NU 010 & NU 011). | As of January 2016, these courses are now mandatory for all students. |
| **FACULTY** | | | |
| A. Focus on retention and shared governance.<br><br>• Nursing administration analysis of workload of Brookfield/Kenosha nursing faculty. | August 2016 Ongoing, reviewed each semester<br><br>August | Revised faculty course assignments and hired new faculty to achieve compliance.<br>*See Appendix V: Fall Schedule | As of August 2016, five new nursing faculty have been hired. Fall schedule developed with attention to workload and onboarding of new faculty. |

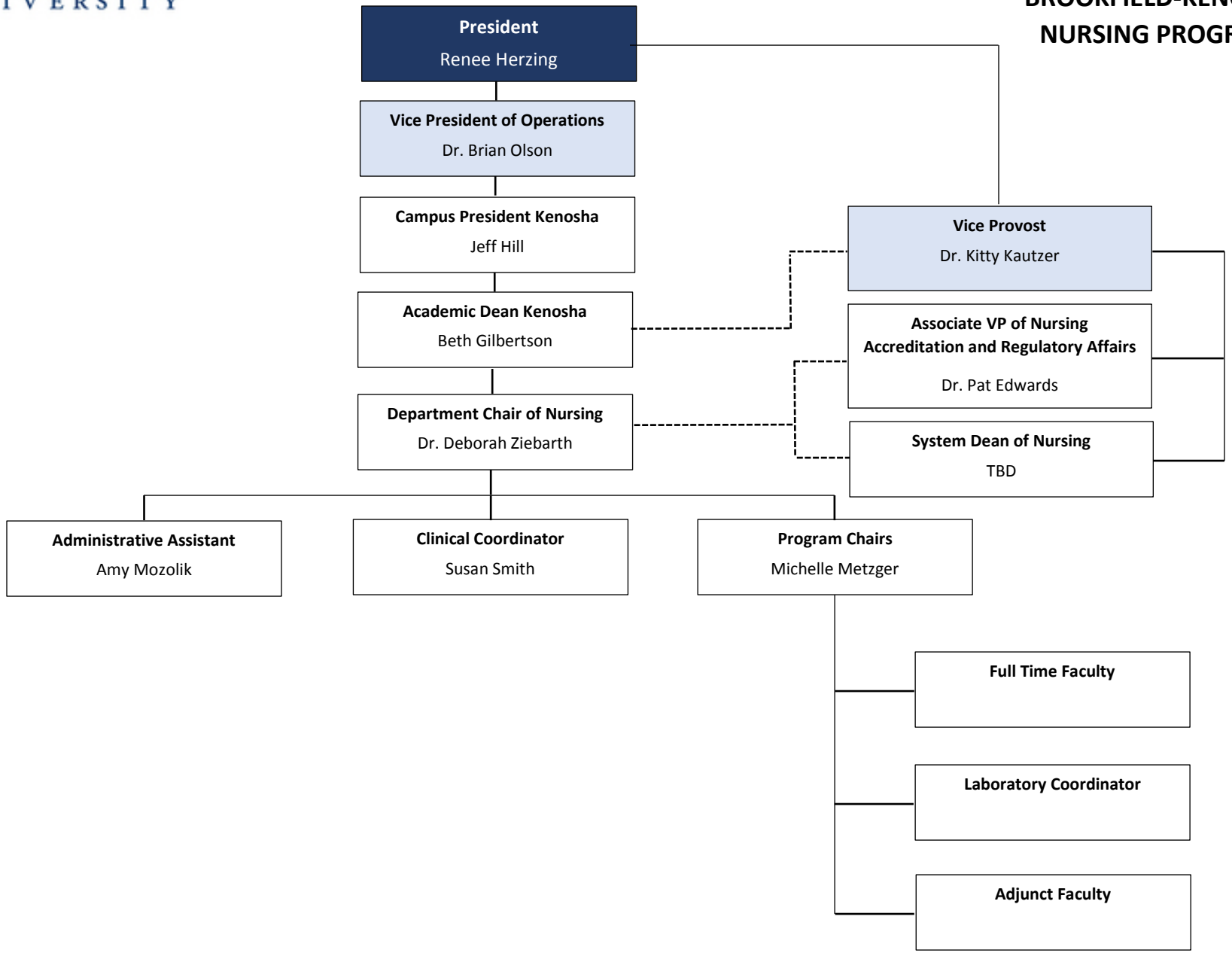
| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| • Hired Two MSN-RNs faculty members (acute care experienced) and scheduled for training as Simulation Coordinators. | 2016 | 2 simulation coordinators hired and on-boarded<br>*See Appendix VI: Job Description | Two Simulation Coordinators hired and Society for Simulation in Health Care (SSH) Certification Program information provided. |
| B. Improve Instruction and Curriculum Implementation | | | |
| • Engage Faculty Development Expert to review and enhance faculty developmental plans. | July 2016 | Program organizational chart reflects Faculty Development Expert role. Classroom observations completed on all faculty who taught in the July 2016 term. | As of July 2016, Dr. Beth Markham began faculty classroom observations and faculty 1:1 meetings. |
| • Formalized onboarding for new nursing faculty. | August 2016 | 1:1 meetings convened with each faculty member to review classroom observation and identify opportunities for improvement.<br>• Updated faculty developmental plans for each faculty member based upon classroom observation feedback | Orientation for new faculty in process |
| • Continuous Education of faculty to ATI, its products, course integration, and 1:1 meetings with ATI educator. | April 2016, July 2016 | New and novice faculty will know curricular structure and develop skills in instructional strategies and | This objective has been met. We had 100% of faculty participation at meetings. |

| ACTIONS | DATE | EVIDENCE | PROGRESS TO DATE |
|---|---|---|---|
| | | outcomes measurement.<br>*See Appendix V: Fall Schedule and Appendix VII: Faculty Orientation Checklist<br><br>Attendance at ATI meeting and course integration of ATI products.<br>*See Appendix VIII: ATI Implementation Plan | |
| **CURRICULUM** | | | |
| A. Faculty and external review committee will meet to evaluate course progression, prerequisites, and content mapping. | September 2017 | Faculty and external review committee will meet to evaluate course progression, prerequisites, and content mapping. | Evaluation will inform curriculum road map and budget for 2017. |

Action Committee for the WBON plan included Dr. Beth Markham, Dr. Teri Kaul, Dr. Pat Schroeder, Dr. Pat Edwards, Dr. Kitty Kautzer, Beth Gilbertson, Michelle Metzger, and Dr. Deborah Ziebarth.

## Organization Chart

## BROOKFIELD-KENOSHA NURSING PROGRAM



HERZING UNIVERSITY

# COURSE SYLLABUS

## NU 447

| FACULTY CONTACT INFORMATION | |
|---|---|
| **Instructor** | Michelle Metzger |
| **Phone Number** | 530 200-5296 cell |
| **Herzing e-mail** | Mmetzger@herzing.edu |

| DAY | OFFICE HOURS (Central Time) |
|---|---|
| **Monday** | 09-1530 |
| **Tuesday** | After Class Kenosha |
| **Wednesday** | After Class Brookfield |
| **Thursday** | 09-1530 |
| **Friday** | 09-1530 |

| | | | | |
|---|---|---|---|---|
| **Instructional Delivery Method** | **Campus Based** | | | |
| **Class Location** | | | | |
| **Semester** | Summer 2016 | | | |
| **Course Code** | NU 447 | | | |
| **Course Title:** | Adult Health III/Nursing Practicum | | | |
| **Course Description** | This course expands on previous nursing knowledge and skills to provide care to patients/clients that have complex health stressors with unpredictable outcomes. The focus is on caring for patients in specialty settings such as critical care, cardiovascular care, surgery, and emergency care. The student will demonstrate synthesis of the program objectives in the both the classroom and clinical setting, readiness for beginning work as a nurse generalist, and potential for success on the NCLEX-RN licensure examination. An opportunity for review of essential clinical skills and synthesis of prior learning with guided review by faculty in the laboratory component assists in the synthesis of theory, assessment, and competence as well as NCLEX-RN preparation. The student will complete the clinical component in either a precepted or advanced practicum setting. | | | |
| **Credit Hours Contact Hours** | **# Semester Credit Hours: 6** | | | |
| | **Lecture Hours** | **Laboratory Hours** | **Internship/Externship/ Clinical/Practicum Hours** | **Total Contact Hours** |
| | **30** | **30** | **135** | **195** |
| **Study Time** | Lecture, Lab, or Internship/Externship/Clinical/Practicum hours as indicated on the syllabus represent scheduled hours spent engaged in learning activities. Students should expect to spend a minimum of two additional hours engaged in learning activities outside of class for each one hour identified as lecture; students should expect to spend one hour engaged in learning activities outside of class for each two hours of scheduled laboratory time. Learning activities outside of class support the achievement of one or more course learning objectives and may be spent reading textbook material, completing homework assignments, preparing for lab assignments, engaged in drill and practice exercises, working on case studies, completing workbook activities, or conducting library research. Additional study time outside of scheduled | | | |

| | |
|---|---|
| | Internship/Externship/Clinical hours is typically not expected.<br><br>The total amount of time that students spend engaged in learning activities is consistent, regardless of instructional delivery method. For example, students enrolled a three credit lecture course should expect to spend 45 hours in scheduled class time and an additional 90 hours engaged in learning activities outside of the classroom. Online or blended students should expect to spend the equivalent total of 135 hours engaged in learning activities if they are enrolled in the same course.<br><br>Determination of the amount of time that a student should expect to spend engaged in learning activities is based upon faculty judgment regarding the average student. The amount of time spent engaged in learning activities is expected to vary among students, based upon previous knowledge of the content, learning style, learning ability, difficulty of the course, and student motivation**.** |
| **Guide to Student Engagement in Learning Activities** | *The timeframes provided below are estimates based upon the average student.*<br><br>Lower level reading (10-20 pages) — 1 hour<br>Higher level reading (10-20 pages) — 2 hours<br>Construction of 1 page paper (250 words) — 2 hours<br>Development of 10 minute speech — 2 hours<br>Watch video lecture — 1 hour<br>Read, research and respond to discussion board posting — 1 hour<br>Preparation for unit examination — 2 hours |
| **Course Length** | **16 Weeks** |
| **Prerequisites** | **NU 402: Family Nursing**<br><br>**NU 412: Community Nursing** |
| **Co-requisites** | **NU 450 Nursing Leadership and Management** |
| **Course Learning Objectives** | **Upon successful completion of this course, students should be able to:**<br>1. Practice using caring, compassionate, culturally competent, and evidence-based practices in the roles of the baccalaureate nurse using the nursing process to provide patient/client-centered care in a variety of healthcare settings.<br>2. Use a broad base of techniques to communicate effectively with clients, families, healthcare teams, and communities.<br>3. Use critical thinking and decision making, local, state, national, and global policies, legislative concepts, and healthcare economics to effect quality healthcare and the evolving healthcare system.<br>4. Integrate knowledge and skills in nursing leadership and management, quality improvement, and patient safety, as required, to provide healthcare.<br>5. Integrate knowledge and skills to promote health and prevent disease across the lifespan and the continuum of healthcare environments.<br>6. Practice professionalism, including the inherent values of altruism, autonomy, human dignity, integrity, and social justice.<br>7. Formulate a professional ethic that includes lifelong learning and continuous professional development in an ever-evolving healthcare environment.<br>8. Think critically at a conceptual level and by using mathematical analysis as well as |

| | |
|---|---|
| | the scientific method, write and speak effectively, use basic computer applications, and understand human behavior in the context of the greater society in a culturally diverse world. |
| **Required Textbook(s)** | Chernecky, C.C. and Berger, B.J. (2012). *Laboratory Tests and diagnostic procedures* (6th Ed.). St. Louis: Sanders (Elsevier). ISBN: 13- 9781455706945<br><br>Lewis, Dirksen, Heitkemper, Bucher, & Camera. (2014). *Medical-surgical nursing: Assessment and management of clinical problems*, (9th Ed.). St. Louis: Elsevier. ISBN:13- 9780323086783<br><br>Silvestri, Linda A. (2013). Saunders *comprehensive review for the NCLEX-RN examination,* (6th Ed.). St. Louis: Elsevier. ISBN: 13- 9781455727551<br><br>Vallerand, April Hazard and Sanoski, Cynthia C. (2013). *Davis's drug guide for nurses* (14th Ed.), F. A. Davis. ISBN: 13- 9780803639768 |
| **Optional Textbook(s)** | American Psychological Association. (2009). *Publication manual of the American Psychological Association* (6th Ed.) Washington, DC. American Psychological Association.<br><br>ATI. (2013). *RN adult medical surgical nursing* (9.0 Ed.) Assessment Technologies Institute, LLC.<br><br>Jarvis, C. (2011). *Physical examination and health assessment* (6th Ed.). St. Louis, MO. W. B. Saunders. ISBN:13- 9781455728107<br>Huether, Sue E. and McCance, Kathryn L. (2011). *Understanding pathophysiology* (5th Ed.). St. Louis: Elsevier. ISBN: 9780323078917<br><br>Perry, A. G., Potter, P. A. (2010). *Clinical nursing skills and techniques (7th ed.)* St. Louis, MO: Mosby Elsevier. ISBN: 13- 9780323083836<br><br>Pickar, G.D., & Abernethy, A.P. (2015) *Dosage Calculations* (4rd Ed.). Clifton Park, NY: Delmar Cengage ISBN: 13- 9781285429458<br><br>Potter, P.A. & Perry, A.G. (2009). *Fundamentals of Nursing* (7th Ed.). St. Louis, MO: Mosby Elsevier ISBN: 13- 9780323079334 |
| **Additional Learning Material(s)** | Virtual ATI / Capstone ATI Assessments |

| | | | Course Learning Objective Supported | Points | DUE DATE |
|---|---|---|---|---|---|
| | Week 1<br>May 4 | **Topic(s): Start** Cardiac<br>**Reading:** , Chapter 36, Chapter 38 pg 841-846,<br>**Discussions: Review Syllabus for NU 447/NU 447L**<br>**Assignment(s): Med/Surg ATI book pg 294-385, 420-434**<br>**Assessment(s):** Discuss ATI Capstone/Virtual ATI | **1** | | |
| | Week 2<br>May 11 | **Topic(s):** Cardiac<br>**Reading:** Chapter 36 continued<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book pg 294-385, 420-434**<br>**Assessment(s):** WebEx for ATI Capstone | **1,5** | **Drug Calc Test (P/F)** | |
| | Week 3<br>May 18 | **Topic(s):** Critical Care<br>**Reading:** Chapter 66<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book pg 500-509**<br>**Assessment(s):** Pre Capstone Assessment test during Lab Class | **1,3** | | |
| | Week 4<br>May 25 | **Topic(s):** Start Respiratory<br>**Reading:** Chapter 68, Chapter 17 for Acid Base<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book pg 179-229, 258-292**<br>**Assessment(s): Fundamentals Assessment** | **7** | **Exam 1<br>150 points<br>Cardiac** | |
| | Week 5<br>June 1 | **Topic(s):** Continue Respiratory<br>**Reading:** Chapter 68, Chapter 17 for Acid Base<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book pg 179-229, 258-292**<br>**Assessment(s): Pharmacology Assessment** | **7** | | |
| | Week 6<br>June 8 | **Topic(s):** Emergency Nusrsing<br>**Reading:** Chapter 69<br>**Discussions:** 39T<br>**Assignment(s): Leadership ATI book pg 94-108, Med/Surg ATI book pg 9-17**<br>**Assessment(s): Medical/Surgical Assessment** | **1,2** | **Exam 2<br>150 points<br>Respiratory** | |
| | Week 7<br>June 15 | **Topic(s):** Emergency Nursing continued<br>**Reading:** Chapter 69<br>**Discussions:** 39T<br>**Assignment(s): Leadership ATI book pg 94-108, Med/Surg ATI book pg 9-17**<br>**Assessment(s): Maternal Child Assessment** | **1,2** | | |
| | Week 8<br>June 22 | **Topic(s):** none<br>**Reading: none**<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book 145-178**<br>**Assessment(s): Care of the Child Assessment** | | **Exam 3<br>150 points<br>Emergency** | |

| | | | Course Learning Objective Supported | Points | DUE DATE |
|---|---|---|---|---|---|
| | Week 9<br>July 13 | **Topic(s):** Neuro<br>**Reading:** Chapter 57 and Chapter 58<br>**Discussions:** 39T<br>**Assignment(s): Med/Surg ATI book 145-178**<br>**Assessment(s):**<br>**Mental Health Assessment** | **6** | | |
| | Week 10<br>July 20 | **Topic(s):**, Continue Neuro<br>**Reading:** Chapter 57, Chapter 58<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s): Leadership/Community** | **6** | | |
| | Week 11<br>July 27 | **Topic(s):** Burns<br>**Reading:** Chapter 67<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s):** Post Test/Transition to Virtual | **1,3** | **Exam 4**<br>**150 points**<br>**Neuro** | |
| | Week 12<br>August 3 | **Topic(s):** MODS, Sepsis<br>**Reading:** Chapter 67<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s):** Begin Nurse Logic | **1,3** | | |
| | Week 13<br>August 10 | **Topic(s):** Mods, Sepsis<br>**Reading:** 39T<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s):** Fundamentals | **3** | **Med/Surg**<br>**Proctored**<br>**ATI** | |
| | Week 14<br>August 17 | **Topic(s):** Organ Procurement<br>**Reading:** 39T<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s):** Pharmacology Virtual | **3** | **Predictor**<br>**ATI** | |
| | Week 15<br>August 24 | **Topic(s):** Final<br>**Reading:** Comprehensive<br>**Discussions:** 39T<br>**Assignment(s):** 39T<br>**Assessment(s):** Medical surgical Virtual | **1,2,3,4,5,6,7** | **Final**<br>**200 points**<br>**Comprehensive** | |

| Grade Summary | Points |
|---|---|
| Clinical Case Study (100 points) | 10% |
| Virtual ATI/ATI Capstone | Pass/Fail for Lab. |
| ATI Proctored Med/Surg (50 points)<br>ATI Predictor (50 points) | 10% (5% each) |
| Exam 1 (150 points)<br>Exam 2 (150 points)<br>Exam 3 (150 points)<br>Exam 4 (150 points) | 15% each<br>Or<br>60% total |
| Final Exam (200 points) | 20% |

| | |
|---|---|
| **Totals 1000 points** | **100%** |

| Minimum Grade Scale | |
|---|---|
| A | 93.00% - 100.00% |
| A- | 90.00% - 92.99% |
| B+ | 87.00% - 89.99% |
| B | 83.00% - 86.99% |
| B- | 80.00% - 82.99% |
| C+ | 76.00% - 79.99% |
| F | 75.99% or below |

**POLICIES**

University policies, such as attendance philosophy, notification of absences, extenuating circumstances, accommodation requests, academic dishonesty, grading and grading symbols, and student conduct are included in the University catalog. Students should reference the catalog for the complete listing of policies.

**Note: In some cases, program and/or course specific information may be appended to the syllabus. In these instances, students must consider the syllabus to be inclusive of any appended information, and as such, students must adhere to all course requirements as described in the document in its entirety.**

HERZING UNIVERSITY

# COURSE SYLLABUS ADDENDUM

| | | | |
|---|---|---|---|
| **Instructor** | | | |
| **Course Code:** | NU 447 | **Semester:** | |
| **Course Name:** | **Adult Health III/Nursing Practicum** | | |

## Topic One: PROGRAM OUTCOMES TABLE

| COURSE OUTCOMES | CURRICULUM THREADS | PROGRAM OUTCOMES | CCNE ESSENTIALS OF BSN EDUCATION | ANA SCOPE AND STANDARDS | NLN OUTCOMES | QSEN | IOM |
|---|---|---|---|---|---|---|---|
| 1. Practice using caring, compassionate, culturally competent, and evidence-based practices in the roles of the baccalaureate nurse using the nursing process to provide patient/client-centered care in a variety of healthcare settings. | Person<br>Nursing<br><br>Nursing Process<br><br>Professional Role<br><br>Caring<br><br>Compassion<br><br>Safety<br><br>Evidence Based Practice<br><br>Culture<br><br>Diversity<br><br>Environment<br><br>Critical Thinking | 1 | Essential I: Liberal Education<br><br>Essential III: Scholarship for EBP<br><br>Essential VII: Clinical Prevention and Population Health<br><br>Essential IX: Baccalaureate Generalist Nursing Practice | 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,, 13, 14, 15, 16 | 1, 2, 3 | 1, 2, 3, 4, 5, 6, | 1, 2, 3, 4 |
| 2. Use a broad base of techniques to effectively communicate with clients, families, healthcare teams, and communities. | Communication<br><br>Society<br><br>Nursing<br><br>Professional Role | 2 | Essential IV: Information Managements and Application of Patient Care Technology<br><br>Essential VI: Interprofession al Communicatio n & Collaboration | 11, 12, 13 | 3 | 2 | 2 |
| 3. Use critical thinking and decision making, local, state, national and global policies, | Critical Thinking<br><br>Society<br><br>Nursing | 3 | Essential V: Health Care Policy, Finance, and Regulatory Environment | 6, 14 | 2, 4 | 4, 6 | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| legislative concepts, and healthcare economics to effect quality healthcare and the evolving healthcare system. | Health | | Essential II: Basic Organizational and Systems Leadership<br><br>Essential VII: Clinical Prevention and Population Health | | | | |
| 4. Integrate knowledge and skills in nursing leadership and management, quality improvement, and patient safety as required to provide healthcare. | Nursing<br><br>Communication<br><br>Evidence Based Practice<br><br>Safety | 4 | Essential II: Basic Organizational and Systems Leadership<br><br>Essential V: Healthcare Policy<br><br>Essential VI: Interprofessional Communication and Collaboration | 12 | 3 | 2, 4 | 2 |
| 5. Integrate knowledge and skills to promote health and prevent disease across the life span and the continuum of healthcare environments. | Health<br><br>Society<br><br>Professional Role | 5 | Essential VII: Clinical Prevention and Population Health | 13 | 3 | 3 | 1, 4 |
| 6. Practice professionalism including the inherent values of altruism, autonomy, human dignity, integrity, and social justice. | Professional Role<br><br>Nursing<br><br>Society | 6 | Essential VIII: Professionalism and Professional Values | 14 | 3 | 2 | 2 |
| 7. Formulate a professional ethic that includes life-long learning and continuous professional development in an ever-evolving healthcare environment. | Professional Role<br><br>Communication<br><br>Evidence Based Practice | 7 | Essential I: Liberal Education<br><br>Essential III: Scholarship and Evidence Based Practice<br><br>Essential VIII: Professionalism and Professional Values | 14 | 3 | 4 | 2 |
| 8. Think critically at a conceptual level and by using mathematical | Critical Thinking<br><br>Evidence Based Practice | 8 | Essential I: Liberal Education<br><br>Essential III: | 8 | 2 | 5, 6 | 4 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| analysis as well as the scientific method, write and speak effectively, use basic computer applications, and understand human behavior in the context of the greater society in a culturally diverse world. | Communication<br><br>Professional Role<br><br>Culture<br><br>Diversity | | Scholarship and Evidence Based Practice<br><br>Essential VIII: Professionalism and Professional Values | | | | |

## Topic Two: Additional Grading Policies

### A. ATI Grading Policy

* Number of points earned from ATI testing will be based on the demonstrated level of proficiency earned by the student on the ATI examination. Points earned will be as follows for Medical Surgical Proctored Assessment:

Level 1 = 30% of total points (Can receive an additional 20% with Remediation)
Level 2 = 50% of total points (Can receive an additional 30% with Remediation)
Level 3 = 80% of total points (Can receive an additional 20% with Remediation)

* Number of points earned from ATI testing will be based on the demonstrated elvel of proficiency earned by the student on the ATI examination. Points earned will be as follows for the Comprehensive Predictor Proctored Assessment:

95% or Above= 80% of total points (Can receive an additional 20% with Remediation)
90% or Above= 50% of total points (Can receive an additional 30% with Remediation)
85% or above = 30% of total points (Can receive an additional 20% with Remediation)
84.9 or below = 0% of total points (Can receive an additional 20% with Remediation)

B. CLINICAL GRADING POLICY

## Topic Three: ADDITIONAL COURSE POLICIES

A. SUMMISSION OF LATE WORK (Late work is not accepted)

a. Case study is do by the last week of your clinical rotation! If you are in Term A for clinical your Case study must to turned in by March 4, 2016. Late submission will not be accepted for Term A

b. Term B clinical your case study is due by April 21, 2016. Case study will not be accepted after the 21st.

## Topic Four: CLINICAL ROTATION AND CLINICAL EVALUATION TOOL with GUIDELINES

**All Clinical Paperwork is in the folder provided to by instructor**

**Appendix III Example Study Plan**

| Student s name (Enrolled: 05/19/16) |
|---|
| Beginning Review - Completing Nurse Logic to enhance test taking skills.<br><br>08/17/2016 - NurseLogic Testing and Remediation Advanced - 90.0<br>08/17/2016 - NurseLogic Testing and Remediation Advanced - 30.0<br>08/17/2016 - NurseLogic Testing and Remediation Beginner - 75.0<br>08/17/2016 - RN Adult Medical Surgical 2013 Form E - 65.6<br>08/17/2016 - NurseLogic Priority Setting Frameworks Advanced - 80.0 |
| Beginning Review - Completing Nurse Logic to enhance test taking skills.<br><br>08/17/2016 - RN Adult Medical Surgical 2013 Form E - 65.6<br>08/17/2016 - NurseLogic Priority Setting Frameworks Advanced - 80.0<br>08/17/2016 - NurseLogic Priority Setting Frameworks Beginner - 80.0<br>08/17/2016 - NurseLogic Nursing Concepts Advanced - 90.0<br>08/17/2016 - NurseLogic Nursing Concepts Beginner - 75.0 |
| No Engagement - No active participation in review over the last 2 weeks. Email/message sent to encourage participation in the review. |
| No Engagement - No active participation in review over the last week. Email/message sent to encourage participation in the review. |
| Beginning Review - Completing Nurse Logic to enhance test taking skills.<br><br>08/02/2016 - NurseLogic Nursing Concepts Beginner - 70.0<br>08/02/2016 - NurseLogic  nowledge and Clinical Judgment Advanced - 80.0<br>07/30/2016 - RN Learning System Medical-Surgical: Cardiovascular and Hematology - 50.0<br>07/29/2016 - RN Learning System Fundamentals 1 - 77.5<br>07/29/2016 - NurseLogic  nowledge and Clinical Judgment Advanced - 55.0 |
| Beginning Review - A study plan was recommended as a guide based on the Comprehensive assessment score and the student's time commitment to the review.<br><br>07/30/2016 - RN Learning System Medical-Surgical: Cardiovascular and Hematology - 50.0<br>07/29/2016 - RN Learning System Fundamentals 1 - 77.5<br>07/29/2016 - NurseLogic  nowledge and Clinical Judgment Advanced - 55.0<br>07/28/2016 - NurseLogic  nowledge and Clinical Judgment Beginner - 75.0<br>07/27/2016 - RN ATI Capstone Proctored Comprehensive Assessment B - 70.7 |
| Beginning Review - Welcome to  irtual-ATI communication sent with request of time commitment to engage in the review.<br><br>07/26/2016 - RN Leadership Online Practice 2013 A - 76.7<br>07/23/2016 - RN Comprehensive Online Practice 2013 A - 69.3<br>07/20/2016 - RN Capstone Content Review Leadership and Community Health 2013 - 68.0 |

07/20/2016 - RN Leadership Online Practice 2013 A - 51.7
07/12/2016 - RN Capstone Content Review Mental Health 2013 - 62.0

**Appendix IV: Nursing Tutor's Schedule**

1. First Week of the Month
    - Tuesday: Kenosha 10-4pm
    - Wednesday: Brookfield 10-4pm
    - Thursday: Brookfield 1-5pm

2. Second week of the Month
    - Tuesday: Brookfield 10-4pm
    - Wednesday: Kenosha 10-4pm
    - Thursday: Kenosha1-5pm

3. Third week of the month
    - Tuesday: Kenosha 10-4pm
    - Wednesday: Brookfield 10-4pm
    - Thursday: Brookfield 1-5pm

4. Fourth week of the Month
    - Tuesday: Brookfield 10-4pm
    - Wednesday: Kenosha 10-4pm
    - Thursday: Kenosha 1-5pm

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| | |
|---|---|
| 1) Name and Title of Person Submitting the Request:<br><br>**Dan Williams** | 2) Date When Request Submitted:<br><br>Items will be considered late if submitted after 4:30 p.m. and less than:<br>▪ 10 work days before the meeting for Medical Board<br>▪ 14 work days before the meeting for all others |

3) Name of Board, Committee, Council, Sections:

**Wisconsin Board of Nursing**

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **September 8, 2016** | ☐ Yes<br>☐ No | **Mary Muse appearance -Discussion and Consideration as to nursing within Corrections** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☒ Yes by<br>☐ No | N/A |

10) Describe the issue and action that should be addressed:

Mary Muse is employed as a nurse within Wisconsin DOC and will appear before the Board for a discussion with the Board as to the aspect of nursing in the correctional setting.

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and Title of Person Submitting the Request: | 2) Date When Request Submitted: |
|---|---|
| **Sharon Henes**<br>**Administrative Rules Coordinator** | **26 August 2016**<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |

3) Name of Board, Committee, Council, Sections:

**Board of Nursing**

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **8 September 2016** | ☐ Yes<br>☐ No | **Prescribing Controlled Substances Guidelines (Act 269) – Discussion and Consideration** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☐ Yes (Fill out Board Appearance Request)<br>☐ No | |

10) Describe the issue and action that should be addressed:

11) Authorization

*Sharon Henes* — *26 August 2016*

Signature of person making this request — Date

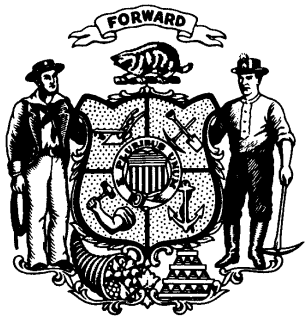
Supervisor (if required) — Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — Date

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

*Revised 8/13*

# State of Wisconsin




Date of enactment: **March 17, 2016**
**2015 Assembly Bill 660** Date of publication*: **March 18, 2016**

# 2015 WISCONSIN ACT 269

AN ACT ***to repeal*** 448.05 (6) (at); ***to renumber*** 440.035; ***to amend*** 440.035 (title), 448.05 (6) (a), 448.07 (1) (b) and 452.12 (4); and ***to create*** 227.01 (13) (zk) and 440.035 (2m) of the statutes; **relating to:** guidelines for prescribing controlled substances and the examination authority of the Medical Examining Board.

***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

**SECTION 1.** 227.01 (13) (zk) of the statutes is created to read:

227.01 **(13)** (zk) Are guidelines issued under s. 440.035 (2m).

**SECTION 2.** 440.035 (title) of the statutes is amended to read:

**440.035** (title) **General duties <u>and powers</u> of examining boards and affiliated credentialing boards.**

**SECTION 3.** 440.035 of the statutes is renumbered 440.035 (1m).

**SECTION 4.** 440.035 (2m) of the statutes is created to read:

440.035 **(2m)** The medical examining board, the podiatry affiliated credentialing board, the board of nursing, the dentistry examining board, or the optometry examining board may issue guidelines regarding best practices in prescribing controlled substances, as defined in s. 961.01 (4), for persons credentialed by that board who are authorized to prescribe controlled substances.

**SECTION 5.** 448.05 (6) (a) of the statutes, as affected by 2013 Wisconsin Act 240, is amended to read:

448.05 **(6)** (a) Except as provided in pars. (am)~~,~~ <u>and</u> (ar)~~, and (at)~~, the board shall examine each applicant it finds eligible under this section in such subject matters as the board deems applicable to the class of license or certificate which the applicant seeks to have granted. Examinations may be both written and oral. In lieu of its own examinations, in whole or in part, the board may make such use as it deems appropriate of examinations prepared, administered, and scored by national examining agencies, or by other licensing jurisdictions of the United States or Canada. The board shall specify passing grades for any and all examinations required.

**SECTION 6.** 448.05 (6) (at) of the statutes, as created by 2013 Wisconsin Act 240, is repealed.

**SECTION 7.** 448.07 (1) (b) of the statutes is amended to read:

448.07 **(1)** (b) The board shall maintain the register required by s. 440.035 ~~(4)~~ <u>(1m) (d)</u>, which shall be divided according to the activity for which the registrant is licensed or certified. The board shall make copies available for purchase at cost.

**SECTION 8.** 452.12 (4) of the statutes is amended to read:

452.12 **(4)** REGISTER OF BROKERS AND SALESPERSONS. The board shall include in the register the board maintains under s. 440.035 ~~(4)~~ <u>(1m) (d)</u> the names of all brokers and salespersons whose licenses were revoked

* Section 991.11, WISCONSIN STATUTES: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication."

within the past 2 years. The register shall be available for purchase at cost.

Wisconsin Department of Safety and Professional Services
Division of Policy Development
1400 E. Washington Ave
PO Box 8366
Madison WI 53708-8366

Phone: 608-266-2112
Web: http://dsps.wi.gov
Email: dsps wisconsin.gov

**Scott Walker, Governor**
**Dave Ross, Secretary**

# Wisconsin Medical Examining Board Opioid Prescribing Guideline

**Scope and purpose of the guideline**: To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

**1) Identify and treat the cause of the pain, use non-opioid therapies**
Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

**2) Start low and go slow**
When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

**3) Close follow-up**
Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

**What's included in the guideline?**
The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

**1) Determining when to initiate or continue opioids**
-Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
-Establishment of treatment goals
-Discussion of risks and benefits of therapy with patients

**2) Opioid selection, dosage, duration, follow-up and discontinuation**
-Selection of immediate-release or extended-release and long-acting opioids
-Dosage considerations
-Duration of treatment
-Considerations for follow-up and discontinuation of opioid therapy

**3) Assessing risk and addressing harms of opioid use**
-Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
-Review of prescription drug monitoring program (PDMP) data
-Use of urine drug testing
-Considerations for co-prescribing benzodiazepines
-Arrangement of treatment for opioid use disorder

## Prescription Opioid Guideline

**1.** Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

**2.** In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

**3.** A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.

**a.** Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.

**b.** Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.

**c.** Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

**4.** Opioids should not necessarily be the first choice in treating acute or chronic pain.

**a.** Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid

therapy. Although opioids could be simultaneously prescribed if it is apparent from the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

**b.** Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.

**c.** Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. **Note:** There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

**d.** Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

**5.** Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

**6.** Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

**7.** Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

**8.** Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

**9.** Prescribing of opioids is not encouraged in patients concurrently taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

**10.** The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

**11.** Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

**a.** Medical history and physical examination targeted to the pain condition

**b.** Nature and intensity of the pain

**c.** Current and past treatments, with response to each treatment

**d.** Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, COPD, etc.)

**e.** Effect of pain on physical and psychological functioning

**f.** Personal and family history of substance abuse

**g.** History of psychiatric disorders associated with opioid abuse (bipolar, ADD/ ADHD, sociopathic, borderline, untreated/severe depression)

**h.** Medical indication(s) for use of opioids.

**12.** Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

**13.** Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioids should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

**a.** Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).

**b.** Components of ongoing assessment of risk include:

**i.** Review of the Prescription Drug Monitoring Program (PDMP) information

**ii.** Periodic urine drug testing (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk

**iii.** Periodic pill counts – at least yearly in low risk cases, more frequently if evidence of increased risk

**iiii.** iolations of the opioid agreement

**14.** All patients on chronic opioid therapy should have informed consent consisting of:

**a.** Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death

**b.** Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects

**15.** Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.

**16.** Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #13.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.

**17.** The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the Tc, predisposing susceptible patients to potentially fatal arrhythmias.

**18.** Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

**19.** During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

**20.** Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

**a.** History of overdose (a relative contraindication to chronic opioid therapy)

**b.** Opioid doses over 50 MMEs/day

**c.** Clinical depression

**d.** Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

**21.** All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner should be able to assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an addiction treatment center which is willing to accept the patient. Simply discharging a patient from the provider's practice after prescribing the medication that led to the complication of opioid use disorder is not considered acceptable.

**22.** Discontinuing Opioid Therapy

**A.** If lack of efficacy of opioid therapy is determined, discontinuation of therapy should be performed.

**1.** Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued.

**2.** Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

**B.** If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

**1.** Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued.

**2.** Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

**3.** Physicians can consider weekly or bi-monthly follow-up during the weaning process.

**C.** If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

**1.** Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up.

## Resources

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Wisconsin Medical Society Opioid Prescribing Principles. https://www.wisconsinmedicalsociety.org/advocacy/boards-councils/society-initiatives/opioid-task-force/opioid-prescribing-principles/

# Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain

## Section I: Preamble

The Michigan Boards of Medicine and Osteopathic Medicine & Surgery recognize that principles of quality medical practice dictate that the people of the State of Michigan have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Boards' position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Boards recognize that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the *U.S. Agency for Health Care and Research Clinical Practice Guidelines* for a sound approach to the management of acute[1] and cancer-related pain[2]. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Boards are obligated under the laws of the State of Michigan to protect the public health and safety. The Boards recognize that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

1. Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. *Clinical Practice Guideline*. AHCPR Publication No. 92-0032. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. February 1992.

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Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

The Boards will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Boards consider to be within the boundaries of professional practice.

## Section II: Guidelines

The Boards have adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

   A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

   The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

   The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

   - urine/serum medication levels screening when requested;
   - number and frequency of all prescription refills; and
   - reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records

The physician should keep accurate and complete records to include

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- evaluations and consultations;
- treatment objectives;
- discussion of risks and benefits;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements; and
- periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

## Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

### Acute Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

### Addiction

Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

### Analgesic Tolerance

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

### Chronic Pain

A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

## Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

## Physical Dependence

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

## Pseudoaddiction

Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

## Substance Abuse

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

## Tolerance

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

# GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

## IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

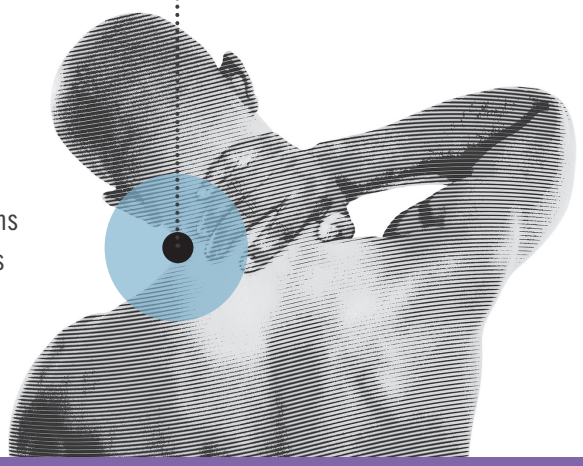
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

### CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

### CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

**4** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

**5** When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

**6** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**7** Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

## ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

**8** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

**9** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

**10** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

**11** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

**12** Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

### CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

Please note: An erratum has been published for this issue. To view the erratum, please click here.

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 65 / No. 1

March 18, 2016

# CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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### Disclosure of Relationship

The Core Expert Group (CEG) members disclose that they have no financial conflicts of interest. Experts disclose the following activities related to the content of this guideline: Pam Archer discloses authorship of the Oklahoma Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines and the Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office Based Setting; Bonnie Burman discloses authorship of the Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain; Jane Ballantyne discloses that she has served as a paid consultant to Cohen Milstein Sellers & Toll, PLLC, and has special advisory committee responsibilities on the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategies committee; Phillip Coffin discloses that in 2012 he provided expert testimony to the California State Assembly regarding a bill to expand naloxone access and reports that he is the principal investigator on a research study of methamphetamine dependence that receives donated injectable naltrexone from Alkermes, Inc.; Gary Franklin discloses authorship of the AMDG Interagency Guideline on Prescribing Opioids for Pain; Erin Krebs discloses that she represented the American College of Physicians at a 2014 Food and Drug Administration meeting on Abuse Deterrent Opioid Formulations; Lewis Nelson discloses his ad-hoc membership on the FDA Drug Safety and Risk Management Advisory Committee; Trupti Patel discloses authorship of the Arizona Opioid Prescribing Guidelines; Robert "Chuck" Rich discloses that he was an author of the 2013 American Academy of Family Physicians position paper on opioids and pain management; Joanna Starrels discloses that she received honoraria from the Betty Ford Institute; Thomas Tape discloses that he was an author of the 2013 American College of Physicians policy position paper on prescription drug abuse. CDC provided 100% of the funding for the supplemental evidence review tasks and meeting support. No foundation or industry support was accepted.

The Opioid Guideline Workgroup (OGW) members disclose that they have no financial conflicts of interest. Experts disclose the following activities related to the content of this guideline: Anne Burns discloses that she participated in a congressional briefing sponsored by Reps. Carter and DeSaulnier on the pharmacist's role of furnishing Naloxone and that she participates on the National Advisory Board for the Prescription Drug Abuse and Heroin Summit. Chinazo Cunningham discloses that her husband is employed by Quest Diagnostics and Dr. Cunningham was recused from any discussion related to urine drug testing. Traci Green discloses that she was previously employed by Inflexxion, a small business that conducts Small Business Innovation Research on behavioral interventions for behavioral health and chronic pain and created several psychometric tools for conducting risk assessment for prescription opioid abuse potential. Dr. Green also discloses that while at the hospital where she is employed, she provided consultation to Purdue Pharma Ltd to design overdose prevention brochures for persons who use diverted prescription opioids non-medically with an emphasis on persons who inject prescription drugs, and not for patients using opioid therapy for pain. Dr. Green was recused from any discussion related to risk assessment tools and patient education materials. Erin Krebs discloses that she served on the CDC Opioid Prescribing Guideline CEG. Christina Porucznik discloses that she served on the CDC Opioid Prescribing Guideline CEG. Greg Terman discloses that he serves as the President of the American Pain Society. Mark Wallace discloses that he served on a Kempharma advisory panel for an abuse-deterrent hydrocodone formulation to treat acute postoperative pain and Dr. Wallace was recused form any discussion related to abuse-deterrent drugs.

The NCIPC Board of Scientific Counselors (BSC) members disclose that they have no financial conflicts of interest. Two BSC members, Traci Green and Christina Porucznik, served on the Opioid Guideline Workgroup. Traci Green discloses that she was previously employed by Inflexxion, a small business that conducts Small Business Innovation Research on behavioral interventions for behavioral health and chronic pain and created several psychometric tools for conducting risk assessment for prescription opioid abuse potential. Dr. Green also discloses that while at the hospital where she is employed, she provided consultation to Purdue Pharma Ltd to design overdose prevention brochures for persons who use diverted prescription opioids non-medically with an emphasis on persons who inject prescription drugs, and not for patients using opioid therapy for pain. Dr. Green was recused from any discussion related to risk assessment tools and patient education materials. Christina Porucznik discloses that she served on the CDC Opioid Prescribing Guideline CEG.

The *MMWR* series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027.

**Suggested citation:** [Author names; first three, then et al., if more than six.] [Title]. MMWR Recomm Rep 2016;65(No. RR-#):[inclusive page numbers].

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# CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

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## Summary

*This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.*

## Introduction

### Background

Opioids are commonly prescribed for pain. An estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription (*1*). In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills (*2*). Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties (*3*). Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication (*2*).

Prevention, assessment, and treatment of chronic pain are challenges for health providers and systems. Pain might go unrecognized, and patients, particularly members of racial and ethnic minority groups, women, the elderly, persons with cognitive impairment, and those with cancer and at the end of life, can be at risk for inadequate pain treatment (*4*). Patients can experience persistent pain that is not well controlled. There are clinical, psychological, and social consequences associated with chronic pain including limitations in complex activities, lost work productivity, reduced quality of life, and stigma, emphasizing the importance of appropriate and compassionate patient care (*4*). Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options.

Chronic pain has been variably defined but is defined within this guideline as pain that typically lasts >3 months or past the time of normal tissue healing (*5*). Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause (*4*). Estimates of the prevalence of chronic pain vary, but it is clear that the number of persons experiencing chronic pain in the United States is substantial. The 1999–2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months (*6*). Based on a survey conducted during 2001–2003 (*7*), the overall prevalence of common, predominantly musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) was estimated at 43% among adults in the

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United States, although minimum duration of symptoms was not specified. Most recently, analysis of data from the 2012 National Health Interview Study showed that 11.2% of adults report having daily pain (*8*). Clinicians should consider the full range of therapeutic options for the treatment of chronic pain. However, it is hard to estimate the number of persons who could potentially benefit from opioid pain medication long term. Evidence supports short-term efficacy of opioids for reducing pain and improving function in noncancer nociceptive and neuropathic pain in randomized clinical trials lasting primarily ≤12 weeks (*9*,*10*), and patients receiving opioid therapy for chronic pain report some pain relief when surveyed (*11*–*13*). However, few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later (*14*). On the basis of data available from health systems, researchers estimate that 9.6–11.5 million adults, or approximately 3%–4% of the adult U.S. population, were prescribed long-term opioid therapy in 2005 (*15*).

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States (*16*). In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly (*17*). Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths (*18*). The Drug Abuse Warning Network estimated that >420,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011, the most recent year for which data are available (*19*). Although clinical criteria have varied over time, opioid use disorder is a problematic pattern of opioid use leading to clinically significant impairment or distress. This disorder is manifested by specific criteria such as unsuccessful efforts to cut down or control use and use resulting in social problems and a failure to fulfill major role obligations at work, school, or home (*20*). This diagnosis has also been referred to as "abuse or dependence" and "addiction" in the literature, and is different from tolerance (diminished response to a drug with repeated use) and physical dependence (adaptation to a drug that produces symptoms of withdrawal when the drug is stopped), both of which can exist without a diagnosed disorder. In 2013, on the basis of DSM-IV diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication (*21*). Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder (*22*–*24*), highlighting the value of guidance on safer prescribing practices for clinicians. For example, a recent study of patients aged 15–64 years receiving opioids for chronic noncancer pain and followed for up to 13 years revealed that one in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages >200 morphine milligram equivalents (MME) died from opioid-related overdose (*25*).

This guideline provides recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain (i.e., pain conditions that typically last >3 months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care. Although the guideline does not focus broadly on pain management, appropriate use of long-term opioid therapy must be considered within the context of all pain management strategies (including nonopioid pain medications and nonpharmacologic treatments). CDC's recommendations are made on the basis of a systematic review of the best available evidence, along with input from experts, and further review and deliberation by a federally chartered advisory committee. The guideline is intended to ensure that clinicians and patients consider safer and more effective treatment, improve patient outcomes such as reduced pain and improved function, and reduce the number of persons who develop opioid use disorder, overdose, or experience other adverse events related to these drugs. Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient's clinical situation, functioning, and life context. The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.

## Rationale

Primary care clinicians report having concerns about opioid pain medication misuse, find managing patients with chronic pain stressful, express concern about patient addiction, and report insufficient training in prescribing opioids (*26*). Across specialties, physicians believe that opioid pain medication can be effective in controlling pain, that addiction is a common consequence of prolonged use, and that long-term opioid therapy often is overprescribed for patients with chronic noncancer pain (*27*). These attitudes and beliefs, combined with increasing trends in opioid-related overdose, underscore the need for better clinician guidance on opioid prescribing. Clinical practice guidelines focused on prescribing can improve clinician knowledge, change prescribing practices (*28*), and ultimately benefit patient health.

Professional organizations, states, and federal agencies (e.g., the American Pain Society/American Academy of Pain Medicine, 2009; the Washington Agency Medical Directors Group, 2015; and the U.S. Department of Veterans Affairs/Department of Defense, 2010) have developed guidelines for opioid prescribing (*29–31*). Existing guidelines share some common elements, including dosing thresholds, cautious titration, and risk mitigation strategies such as using risk assessment tools, treatment agreements, and urine drug testing. However, there is considerable variability in the specific recommendations (e.g., range of dosing thresholds of 90 MME/day to 200 MME/day), audience (e.g., primary care clinicians versus specialists), use of evidence (e.g., systematic review, grading of evidence and recommendations, and role of expert opinion), and rigor of methods for addressing conflict of interest (*32*). Most guidelines, especially those that are not based on evidence from scientific studies published in 2010 or later, also do not reflect the most recent scientific evidence about risks related to opioid dosage.

This CDC guideline offers clarity on recommendations based on the most recent scientific evidence, informed by expert opinion and stakeholder and public input. Scientific research has identified high-risk prescribing practices that have contributed to the overdose epidemic (e.g., high-dose prescribing, overlapping opioid and benzodiazepine prescriptions, and extended-release/long-acting [ER/LA] opioids for acute pain) (*24*,*33*,*34*). Using guidelines to address problematic prescribing has the potential to optimize care and improve patient safety based on evidence-based practice (*28*), as well as reverse the cycle of opioid pain medication misuse that contributes to the opioid overdose epidemic.

## Scope and Audience

This guideline is intended for primary care clinicians (e.g., family physicians and internists) who are treating patients with chronic pain (i.e., pain lasting >3 months or past the time of normal tissue healing) in outpatient settings. Prescriptions by primary care clinicians account for nearly half of all dispensed opioid prescriptions, and the growth in prescribing rates among these clinicians has been above average (*3*). Primary care clinicians include physicians as well as nurse practitioners and physician assistants. Although the focus is on primary care clinicians, because clinicians work within team-based care, the recommendations refer to and promote integrated pain management and collaborative working relationships with other providers (e.g., behavioral health providers, pharmacists, and pain management specialists). Although the transition from use of opioid therapy for acute pain to use for chronic pain is hard to predict and identify, the guideline is intended to inform clinicians who are considering prescribing opioid pain medication for painful conditions that can or have become chronic.

This guideline is intended to apply to patients aged ≥18 years with chronic pain outside of palliative and end-of-life care. For this guideline, palliative care is defined in a manner consistent with that of the Institute of Medicine as care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness. Palliative care can begin early in the course of treatment for any serious illness that requires excellent management of pain or other distressing symptoms (*35*). End-of-life care is defined as care for persons with a terminal illness or at high risk for dying in the near future in hospice care, hospitals, long-term care settings, or at home. Patients within the scope of this guideline include cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, and are under cancer surveillance only. The guideline is not intended for patients undergoing active cancer treatment, palliative care, or end-of-life care because of the unique therapeutic goals, ethical considerations, opportunities for medical supervision, and balance of risks and benefits with opioid therapy in such care.

The recommendations address the use of opioid pain medication in certain special populations (e.g., older adults and pregnant women) and in populations with conditions posing special risks (e.g., a history of substance use disorder). The recommendations do not address the use of opioid pain medication in children or adolescents aged <18 years. The available evidence concerning the benefits and harms of long-term opioid therapy in children and adolescents is limited, and few opioid medications provide information on the label regarding safety and effectiveness in pediatric patients. However, observational research shows significant increases in opioid prescriptions for pediatric populations from 2001 to 2010 (*36*), and a large proportion of adolescents are commonly prescribed opioid pain medications for conditions such as headache and sports injuries (e.g., in one study, 50% of adolescents presenting with headache received a prescription for an opioid pain medication [*37*,*38*]). Adolescents who misuse opioid pain medication often misuse medications from their own previous prescriptions (*39*), with an estimated 20% of adolescents with currently prescribed opioid medications reporting using them intentionally to get high or increase the effects of alcohol or other drugs (*40*). Use of prescribed opioid pain medication before high school graduation is associated with a 33% increase in the risk of later opioid misuse (*41*). Misuse of opioid pain medications in adolescence strongly predicts later onset of heroin use (*42*). Thus, risk of opioid medication use in pediatric populations is of great concern. Additional clinical trial and observational research is needed,

and encouraged, to inform development of future guidelines for this critical population.

The recommendations are not intended to provide guidance on use of opioids as part of medication-assisted treatment for opioid use disorder. Some of the recommendations might be relevant for acute care settings or other specialists, such as emergency physicians or dentists, but use in these settings or by other specialists is not the focus of this guideline. Readers are referred to other sources for prescribing recommendations within acute care settings and in dental practice, such as the American College of Emergency Physicians' guideline for prescribing of opioids in the emergency department (*43*); the American Society of Anesthesiologists' guideline for acute pain management in the perioperative setting (*44*); the Washington Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain, Part II: Prescribing Opioids in the Acute and Subacute Phase (*30*); and the Pennsylvania Guidelines on the Use of Opioids in Dental Practice (*45*). In addition, given the challenges of managing the painful complications of sickle cell disease, readers are referred to the NIH National Heart, Lung, and Blood Institute's Evidence Based Management of Sickle Cell Disease Expert Panel Report for management of sickle cell disease (*46*).

# Guideline Development Methods

## Guideline Development Using the Grading of Recommendations Assessment, Development, and Evaluation Method

CDC developed this guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method (http://www.gradeworkinggroup.org). This method specifies the systematic review of scientific evidence and offers a transparent approach to grading quality of evidence and strength of recommendations. The method has been adapted by the CDC Advisory Committee on Immunization Practices (ACIP) (*47*). CDC has applied the ACIP translation of the GRADE framework in this guideline. Within the ACIP GRADE framework, the body of evidence is categorized in a hierarchy. This hierarchy reflects degree of confidence in the effect of a clinical action on health outcomes. The categories include type 1 evidence (randomized clinical trials or overwhelming evidence from observational studies), type 2 evidence (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies), type 3 evidence (observational studies or randomized clinical trials with notable limitations), and type 4 evidence (clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations). Type of evidence is categorized by study design as well as limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and a constellation of plausible biases that could change observations of effects. Type 1 evidence indicates that one can be very confident that the true effect lies close to that of the estimate of the effect; type 2 evidence means that the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; type 3 evidence means that confidence in the effect estimate is limited and the true effect might be substantially different from the estimate of the effect; and type 4 evidence indicates that one has very little confidence in the effect estimate, and the true effect is likely to be substantially different from the estimate of the effect (*47*,*48*). When no studies are present, evidence is considered to be insufficient. The ACIP GRADE framework places recommendations in two categories, Category A and Category B. Four major factors determine the category of the recommendation: the quality of evidence, the balance between desirable and undesirable effects, values and preferences, and resource allocation (cost). Category A recommendations apply to all persons in a specified group and indicate that most patients should receive the recommended course of action. Category B recommendations indicate that there should be individual decision making; different choices will be appropriate for different patients, so clinicians must help patients arrive at a decision consistent with patient values and preferences, and specific clinical situations (*47*). According to the GRADE methodology, a particular quality of evidence does not necessarily imply a particular strength of recommendation (*48–50*). Category A recommendations can be made based on type 3 or type 4 evidence when the advantages of a clinical action greatly outweigh the disadvantages based on a consideration of benefits and harms, values and preferences, and costs. Category B recommendations are made when the advantages and disadvantages of a clinical action are more balanced. GRADE methodology is discussed extensively elsewhere (*47*,*51*). The U.S. Preventive Services Task Force (USPSTF) follows different methods for developing and categorizing recommendations (http://www.uspreventiveservicestaskforce.org). USPSTF recommendations focus on preventive services and are categorized as A, B, C, D, and I. Under the Affordable Care Act, all "nongrandfathered" health plans (that is, those health plans not in existence prior to March 23, 2010 or those with significant changes to their coverage) and expanded Medicaid plans are required to cover

preventive services recommended by USPSTF with a category A or B rating with no cost sharing. The coverage requirements went into effect September 23, 2010. Similar requirements are in place for vaccinations recommended by ACIP, but do not exist for other recommendations made by CDC, including recommendations within this guideline.

A previously published systematic review sponsored by the Agency for Healthcare Research and Quality (AHRQ) on the effectiveness and risks of long-term opioid treatment of chronic pain (*14*,*52*) initially served to directly inform the recommendation statements. This systematic clinical evidence review addressed the effectiveness of long-term opioid therapy for outcomes related to pain, function, and quality of life; the comparative effectiveness of different methods for initiating and titrating opioids; the harms and adverse events associated with opioids; and the accuracy of risk-prediction instruments and effectiveness of risk mitigation strategies on outcomes related to overdose, addiction, abuse, or misuse. For the current guideline development, CDC conducted additional literature searches to update the evidence review to include more recently available publications and to answer an additional clinical question about the effect of opioid therapy for acute pain on long-term use. More details about the literature search strategies and GRADE methods applied are provided in the Clinical Evidence Review (http://stacks.cdc.gov/view/cdc/38026). CDC developed GRADE evidence tables to illustrate the quality of the evidence for each clinical question.

As identified in the AHRQ-sponsored clinical evidence review, the overall evidence base for the effectiveness and risks of long-term opioid therapy is low in quality per the GRADE criteria. Thus, contextual evidence is needed to provide information about the benefits and harms of nonpharmacologic and nonopioid pharmacologic therapy and the epidemiology of opioid pain medication overdose and inform the recommendations. Further, as elucidated by the GRADE Working Group, supplemental information on clinician and patient values and preferences and resource allocation can inform judgments of benefits and harms and be helpful for translating the evidence into recommendations. CDC conducted a contextual evidence review to supplement the clinical evidence review based on systematic searches of the literature. The review focused on the following four areas: effectiveness of nonpharmacologic and nonopioid pharmacologic treatments; benefits and harms related to opioid therapy (including additional studies not included in the clinical evidence review such as studies that evaluated outcomes at any duration or used observational study designs related to specific opioid pain medications, high-dose opioid therapy, co-prescription of opioids with other controlled substances, duration of opioid use, special populations, risk stratification/mitigation approaches, and effectiveness of treatments for addressing potential harms of opioid therapy); clinician and patient values and preferences; and resource allocation. CDC constructed narrative summaries of this contextual evidence and used the information to support the clinical recommendations. More details on methods for the contextual evidence review are provided in the Contextual Evidence Review (http://stacks.cdc.gov/view/cdc/38027).

On the basis of a review of the clinical and contextual evidence (review methods are described in more detail in subsequent sections of this report), CDC drafted recommendation statements focused on determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use. To help assure the draft guideline's integrity and credibility, CDC then began a multistep review process to obtain input from experts, stakeholders, and the public to help refine the recommendations.

## Solicitation of Expert Opinion

CDC sought the input of experts to assist in reviewing the evidence and providing perspective on how CDC used the evidence to develop the draft recommendations. These experts, referred to as the "Core Expert Group" (CEG) included subject matter experts, representatives of primary care professional societies and state agencies, and an expert in guideline development methodology.* CDC identified subject matter experts with high scientific standing; appropriate academic and clinical training and relevant clinical experience; and proven scientific excellence in opioid prescribing, substance use disorder treatment, and pain management. CDC identified representatives from leading primary care professional organizations to represent the audience for this guideline. Finally, CDC identified state agency officials and representatives based on their experience with state guidelines for opioid prescribing that were developed with multiple agency stakeholders and informed by scientific literature and existing evidence-based guidelines.

Prior to their participation, CDC asked potential experts to reveal possible conflicts of interest such as financial relationships with industry, intellectual preconceptions, or previously stated public positions. Experts could not serve if they had conflicts that might have a direct and predictable effect on the recommendations. CDC excluded experts who had a financial or promotional relationship with a company

* A list of the members appears at the end of this report. The recommendations and all statements included in this guideline are those of CDC and do not necessarily represent the official position of any persons or organizations providing comments on the draft guideline.

that makes a product that might be affected by the guideline. CDC reviewed potential nonfinancial conflicts carefully (e.g., intellectual property, travel, public statements or positions such as congressional testimony) to determine if the activities would have a direct and predictable effect on the recommendations. CDC determined the risk of these types of activities to be minimal for the identified experts. All experts completed a statement certifying that there was no potential or actual conflict of interest. Activities that did not pose a conflict (e.g., participation in Food and Drug Administration [FDA] activities or other guideline efforts) are disclosed.

CDC provided to each expert written summaries of the scientific evidence (both the clinical and contextual evidence reviews conducted for this guideline) and CDC's draft recommendation statements. Experts provided individual ratings for each draft recommendation statement based on the balance of benefits and harms, evidence strength, certainty of values and preferences, cost, recommendation strength, rationale, importance, clarity, and ease of implementation. CDC hosted an in-person meeting of the experts that was held on June 23–24, 2015, in Atlanta, Georgia, to seek their views on the evidence and draft recommendations and to better understand their premeeting ratings. CDC sought the experts' individual opinions at the meeting. Although there was widespread agreement on some of the recommendations, there was disagreement on others. Experts did not vote on the recommendations or seek to come to a consensus. Decisions about recommendations to be included in the guideline, and their rationale, were made by CDC. After revising the guideline, CDC sent written copies of it to each of the experts for review and asked for any additional comments; CDC reviewed these written comments and considered them when making further revisions to the draft guideline. The experts have not reviewed the final version of the guideline.

## Federal Partner Engagement

Given the scope of this guideline and the interest of agencies across the federal government in appropriate pain management, opioid prescribing, and related outcomes, CDC invited its National Institute of Occupational Safety and Health and CDC's federal partners to observe the expert meeting, provide written comments on the full draft guideline after the meeting, and review the guideline through an agency clearance process; CDC reviewed comments and incorporated changes. Interagency collaboration will be critical for translating these recommendations into clinical practice. Federal partners included representatives from the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, FDA, the U.S. Department of Veterans Affairs, the U.S. Department of Defense, the Office of the National Coordinator for Health Information Technology, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, AHRQ, and the Office of National Drug Control Policy.

## Stakeholder Comment

Given the importance of the guideline for a wide variety of stakeholders, CDC also invited review from a Stakeholder Review Group (SRG) to provide comment so that CDC could consider modifications that would improve the recommendations' specificity, applicability, and ease of implementation. The SRG included representatives from professional organizations that represent specialties that commonly prescribe opioids (e.g., pain medicine, physical medicine and rehabilitation), delivery systems within which opioid prescribing occurs (e.g., hospitals), and representation from community organizations with interests in pain management and opioid prescribing.* Representatives from each of the SRG organizations were provided a copy of the guideline for comment. Each of these representatives provided written comments. Once input was received from the full SRG, CDC reviewed all comments and carefully considered them when revising the draft guideline.

## Constituent Engagement

To obtain initial perspectives from constituents on the recommendation statements, including clinicians and prospective patients, CDC convened a constituent engagement webinar and circulated information about the webinar in advance through announcements to partners. CDC hosted the webinar on September 16 and 17, 2015, provided information about the methodology for developing the guideline, and presented the key recommendations. A fact sheet was posted on the CDC Injury Center website (http://www.cdc.gov/injury) summarizing the guideline development process and clinical practice areas addressed in the guideline; instructions were included on how to submit comments via email. CDC received comments during and for 2 days following the first webinar. Over 1,200 constituent comments were received. Comments were reviewed and carefully considered when revising the draft guideline.

## Peer Review

Per the final information quality bulletin for peer review (https://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2005/m05-03.pdf), peer review requirements applied to this guideline because it provides influential

scientific information that could have a clear and substantial impact on public- and private-sector decisions. Three experts independently reviewed the guideline to determine the reasonableness and strength of recommendations; the clarity with which scientific uncertainties were clearly identified; and the rationale, importance, clarity, and ease of implementation of the recommendations.* CDC selected peer reviewers based on expertise, diversity of scientific viewpoints, and independence from the guideline development process. CDC assessed and managed potential conflicts of interest using a process similar to the one as described for solicitation of expert opinion. No financial interests were identified in the disclosure and review process, and nonfinancial activities were determined to be of minimal risk; thus, no significant conflict of interest concerns were identified. CDC placed the names of peer reviewers on the CDC and the National Center for Injury Prevention and Control Peer Review Agenda websites that are used to provide information about the peer review of influential documents. CDC reviewed peer review comments and revised the draft guideline accordingly.

## Public Comment

To obtain comments from the public on the full guideline, CDC published a notice in the *Federal Register* (80 FR 77351) announcing the availability of the guideline and the supporting clinical and contextual evidence reviews for public comment. The comment period closed January 13, 2016. CDC received more than 4,350 comments from the general public, including patients with chronic pain, clinicians, families who have lost loved ones to overdose, medical associations, professional organizations, academic institutions, state and local governments, and industry. CDC reviewed each of the comments and carefully considered them when revising the draft guideline.

## Federal Advisory Committee Review and Recommendation

The National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) is a federal advisory committee that advises and makes recommendations to the Secretary of the Department of Health and Human Services, the Director of CDC, and the Director of NCIPC.* The BSC makes recommendations regarding policies, strategies, objectives, and priorities, and reviews progress toward injury and violence prevention. CDC sought the BSC's advice on the draft guideline. BSC members are special government employees appointed as CDC advisory committee members; as such, all members completed an OGE Form 450 to disclose relevant interests. BSC members also reported on their disclosures during meetings. Disclosures for the BSC are reported in the guideline.

To assist in guideline review, on December 14, 2015, via Federal Register notice, CDC announced the intent to form an Opioid Guideline Workgroup (OGW) to provide observations on the draft guideline to the BSC. CDC provided the BSC with the draft guideline as well as summaries of comments provided to CDC by stakeholders, constituents, and peer reviewers, and edits made to the draft guideline in response. During an open meeting held on January 7, 2016, the BSC recommended the formation of the OGW. The OGW included a balance of perspectives from audiences directly affected by the guideline, audiences that would be directly involved with implementing the recommendations, and audiences qualified to provide representation. The OGW comprised clinicians, subject matter experts, and a patient representative, with the following perspectives represented: primary care, pain medicine, public health, behavioral health, substance abuse treatment, pharmacy, patients, and research.* Additional sought-after attributes were appropriate academic and clinical training and relevant clinical experience; high scientific standing; and knowledge of the patient, clinician, and caregiver perspectives. In accordance with CDC policy, two BSC committee members also served as OGW members, with one serving as the OGW Chair. The professional credentials and interests of OGW members were carefully reviewed to identify possible conflicts of interest such as financial relationships with industry, intellectual preconceptions, or previously stated public positions. Only OGW members whose interests were determined to be minimal were selected. When an activity was perceived as having the potential to affect a specific aspect of the recommendations, the activity was disclosed, and the OGW member was recused from discussions related to that specific aspect of the recommendations (e.g., urine drug testing and abuse-deterrent formulations). Disclosures for the OGW are reported. CDC and the OGW identified ad-hoc consultants to supplement the workgroup expertise, when needed, in the areas of pediatrics, occupational medicine, obstetrics and gynecology, medical ethics, addiction psychiatry, physical medicine and rehabilitation, guideline development methodology, and the perspective of a family member who lost a loved one to opioid use disorder or overdose.

The BSC charged the OGW with reviewing the quality of the clinical and contextual evidence reviews and reviewing each of the recommendation statements and accompanying rationales. For each recommendation statement, the OGW considered the quality of the evidence, the balance of benefits and risks, the values and preferences of clinicians and patients, the cost feasibility, and the category designation

Please note: An erratum has been published for this issue. To view the erratum, please click here.



of the recommendation (A or B). The OGW also reviewed supplementary documents, including input provided by the CEG, SRG, peer reviewers, and the public. OGW members discussed the guideline accordingly during virtual meetings and drafted a summary report of members' observations, including points of agreement and disagreement, and delivered the report to the BSC.

NCIPC announced an open meeting of the NCIPC BSC in the Federal Register on January 11, 2015. The BSC met on January 28, 2016, to discuss the OGW report and deliberate on the draft guideline itself. Members of the public provided comments at this meeting. After discussing the OGW report, deliberating on specific issues about the draft guideline identified at the meeting, and hearing public comment, the BSC voted unanimously: to support the observations made by the OGW; that CDC adopt the guideline recommendations that, according to the workgroup's report, had unanimous or majority support; and that CDC further consider the guideline recommendations for which the group had mixed opinions. CDC carefully considered the OGW observations, public comments, and BSC recommendations, and revised the guideline in response.

# Summary of the Clinical Evidence Review

## Primary Clinical Questions

CDC conducted a clinical systematic review of the scientific evidence to identify the effectiveness, benefits, and harms of long-term opioid therapy for chronic pain, consistent with the GRADE approach (*47*,*48*). Long-term opioid therapy is defined as use of opioids on most days for >3 months. A previously published AHRQ-funded systematic review on the effectiveness and risks of long-term opioid therapy for chronic pain comprehensively addressed four clinical questions (*14*,*52*). CDC, with the assistance of a methodology expert, searched the literature to identify newly published studies on these four original questions. Because long-term opioid use might be affected by use of opioids for acute pain, CDC subsequently developed a fifth clinical question (last in the series below), and in collaboration with a methodologist conducted a systematic review of the scientific evidence to address it. In brief, five clinical questions were addressed:

- The effectiveness of long-term opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for long term (≥1 year) outcomes related to pain, function, and quality of life, and how effectiveness varies according to the type/cause of pain, patient demographics, and patient comorbidities (Key Question [KQ] 1).
- The risks of opioids versus placebo or no opioids on abuse, addiction, overdose, and other harms, and how harms vary according to the type/cause of pain, patient demographics, patient comorbidities, and dose (KQ2).
- The comparative effectiveness of opioid dosing strategies (different methods for initiating and titrating opioids; immediate-release versus ER/LA opioids; different ER/LA opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled, continuous versus as-needed dosing; dose escalation versus dose maintenance; opioid rotation versus maintenance; different strategies for treating acute exacerbations of chronic pain; decreasing opioid doses or tapering off versus continuation; and different tapering protocols and strategies) (KQ3).
- The accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse; the effectiveness of risk mitigation strategies (use of risk prediction instruments); effectiveness of risk mitigation strategies including opioid management plans, patient education, urine drug testing, prescription drug monitoring program (PDMP) data, monitoring instruments, monitoring intervals, pill counts, and abuse-deterrent formulations for reducing risk for opioid overdose, addiction, abuse, or misuse; and the comparative effectiveness of treatment strategies for managing patients with addiction (KQ4).
- The effects of prescribing opioid therapy versus not prescribing opioid therapy for acute pain on long-term use (KQ5).

The review was focused on the effectiveness of long-term opioid therapy on long-term (>1 year) outcomes related to pain, function, and quality of life to ensure that findings are relevant to patients with chronic pain and long-term opioid prescribing. The effectiveness of short-term opioid therapy has already been established (*10*). However, opioids have unique effects such as tolerance and physical dependence that might influence assessments of benefit over time. These effects raise questions about whether findings on short-term effectiveness of opioid therapy can be extrapolated to estimate benefits of long-term therapy for chronic pain. Thus, it is important to consider studies that provide data on long-term benefit. For certain opioid-related harms (overdose, fractures, falls, motor vehicle crashes), observational studies were included with outcomes measured at shorter intervals because such outcomes can occur early during opioid therapy, and such harms are not captured well in short-term clinical trials. A detailed listing of the key questions is provided in the Clinical Evidence Review (http://stacks.cdc.gov/view/cdc/38026).

## Clinical Evidence Systematic Review Methods

Complete methods and data for the 2014 AHRQ report, upon which this updated systematic review is based, have been published previously (*14*,*52*). Study authors developed the protocol using a standardized process (*53*) with input from experts and the public and registered the protocol in the PROSPERO database (*54*). For the 2014 AHRQ report, a research librarian searched MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL for English-language articles published January 2008 through August 2014, using search terms for opioid therapy, specific opioids, chronic pain, and comparative study designs. Also included were relevant studies from an earlier review (*10*) in which searches were conducted without a date restriction, reference lists were reviewed, and ClinicalTrials.gov was searched. CDC updated the AHRQ literature search using the same search strategies as in the original review including studies published before April, 2015. Seven additional studies met inclusion criteria and were added to the review. CDC used the GRADE approach outlined in the ACIP Handbook for Developing Evidence-Based Recommendations (*47*) to rate the quality of evidence for the full body of evidence (evidence from the 2014 AHRQ review plus the update) for each clinical question. Evidence was categorized into the following types: type 1 (randomized clinical trials or overwhelming evidence from observational studies), type 2 (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies), type 3 (observational studies, or randomized clinical trials with notable limitations), or type 4 (clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations). When no studies were present, evidence was considered to be insufficient. Per GRADE methods, type of evidence was categorized by study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects. Results were synthesized qualitatively, highlighting new evidence identified during the update process. Meta-analysis was not attempted due to the small numbers of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of the studies. More detailed information about data sources and searches, study selection, data extraction and quality assessment, data synthesis, and update search yield and new evidence for the current review is provided in the Clinical Evidence Review (http://stacks.cdc.gov/view/cdc/38026).

## Summary of Findings for Clinical Questions

The main findings of this updated review are consistent with the findings of the 2014 AHRQ report (*14*). In summary, evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harms that appears to be dose-dependent. These findings supplement findings from a previous review of the effectiveness of opioids for adults with chronic noncancer pain. In this previous review, based on randomized trials predominantly ≤12 weeks in duration, opioids were found to be moderately effective for pain relief, with small benefits for functional outcomes; although estimates vary, based on uncontrolled studies, a high percentage of patients discontinued long-term opioid use because of lack of efficacy and because of adverse events (*10*).

The GRADE evidence summary with type of evidence ratings for the five clinical questions for the current evidence review are outlined (Table 1). This summary is based on studies included in the AHRQ 2014 review (35 studies) plus additional studies identified in the updated search (seven studies). Additional details on findings from the original review are provided in the full 2014 AHRQ report (*14*,*52*). Full details on the clinical evidence review findings supporting this guideline are provided in the Clinical Evidence Review (http://stacks.cdc.gov/view/cdc/38026).

### Effectiveness

For KQ1, no study of opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for chronic pain evaluated long-term (≥1 year) outcomes related to pain, function, or quality of life. Most placebo-controlled randomized clinical trials were ≤6 weeks in duration. Thus, the body of evidence for KQ1 is rated as insufficient (0 studies contributing) (*14*).

### Harms

For KQ2, the body of evidence is rated as type 3 (12 studies contributing; 11 from the original review plus one new study). One fair-quality cohort study found that long-term opioid therapy is associated with increased risk for an opioid abuse or dependence diagnosis (as defined by ICD-9-CM codes) versus no opioid prescription (*22*). Rates of opioid abuse or dependence diagnosis ranged from 0.7% with lower-dose (≤36 MME) chronic therapy to 6.1% with higher-dose (≥120 MME) chronic therapy, versus 0.004% with no opioids prescribed. Ten fair-quality uncontrolled studies reported estimates of opioid abuse, addiction, and related outcomes (*55*–*65*). In primary care settings, prevalence of opioid dependence

(using DSM-IV criteria) ranged from 3% to 26% (*55*,*56*,*59*). In pain clinic settings, prevalence of addiction ranged from 2% to 14% (*57*,*58*,*60*,*61*,*63–65*).

Factors associated with increased risk for misuse included history of substance use disorder, younger age, major depression, and use of psychotropic medications (*55*,*62*). Two studies reported on the association between opioid use and risk for overdose (*66*,*67*). One large fair-quality retrospective cohort study found that recent opioid use was associated with increased risk for any overdose events and serious overdose events versus nonuse (*66*). It also found higher doses associated with increased risk. Relative to 1–19 MME/day, the adjusted hazard ratio (HR) for any overdose event (consisting of mostly nonfatal overdose) was 1.44 for 20 to 49 MME/day, 3.73 for 50–99 MME/day, and 8.87 for ≥100 MME/day. A similar pattern was observed for serious overdose. A good-quality population-based, nested case-control study also found a dose-dependent association with risk for overdose death (*67*). Relative to 1–19 MME/day, the adjusted odds ratio (OR) was 1.32 for 20–49 MME/day, 1.92 for 50–99 MME/day, 2.04 for 100–199 MME/day, and 2.88 for ≥200 MME/day.

Findings of increased fracture risk for current opioid use, versus nonuse, were mixed in two studies (*68*,*69*). Two studies found an association between opioid use and increased risk for cardiovascular events (*70*,*71*). Indirect evidence was found for endocrinologic harms (increased use of medications for erectile dysfunction or testosterone from one previously included study; laboratory-defined androgen deficiency from one newly reviewed study) (*72*,*73*). One study found that opioid dosages ≥20 MME/day were associated with increased odds of road trauma among drivers (*74*).

## Opioid Dosing Strategies

For KQ3, the body of evidence is rated as type 4 (14 studies contributing; 12 from the original review plus two new studies). For initiation and titration of opioids, the 2014 AHRQ report found insufficient evidence from three fair-quality, open-label trials to determine comparative effectiveness of ER/LA versus immediate-release opioids for titrating patients to stable pain control (*75*,*76*). One new fair-quality cohort study of Veterans Affairs patients found initiation of therapy with an ER/LA opioid associated with greater risk for nonfatal overdose than initiation with an immediate-release opioid, with risk greatest in the first 2 weeks after initiation of treatment (*77*).

For comparative effectiveness and harms of ER/LA opioids, the 2014 AHRQ report included three randomized, head-to-head trials of various ER/LA opioids that found no clear differences in 1-year outcomes related to pain or function (*78–80*) but had methodological shortcomings. A fair-quality retrospective cohort study based on national Veterans Health Administration system pharmacy data found that methadone was associated with lower overall risk for all-cause mortality versus morphine (*81*), and a fair-quality retrospective cohort study based on Oregon Medicaid data found no statistically significant differences between methadone and long-acting morphine in risk for death or overdose symptoms (*82*). However, a new observational study (*83*) found methadone associated with increased risk for overdose versus sustained-release morphine among Tennessee Medicaid patients. The observed inconsistency in study findings suggests that risks of methadone might vary in different settings as a function of different monitoring and management protocols, though more research is needed to understand factors associated with safer methadone prescribing.

For dose escalation, the 2014 AHRQ report included one fair-quality randomized trial that found no differences between more liberal dose escalation and maintenance of current doses after 12 months in pain, function, all-cause withdrawals, or withdrawals due to opioid misuse (*84*). However, the difference in opioid dosages prescribed at the end of the trial was relatively small (mean 52 MME/day with more liberal dosing versus 40 MME/day). Evidence on other comparisons related to opioid dosing strategies (ER/LA versus immediate-release opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled continuous dosing versus as-needed dosing; or opioid rotation versus maintenance of current therapy; long-term effects of strategies for treating acute exacerbations of chronic pain) was not available or too limited to determine effects on long-term clinical outcomes. For example, evidence on the comparative effectiveness of opioid tapering or discontinuation versus maintenance, and of different opioid tapering strategies, was limited to small, poor-quality studies (*85–87*).

## Risk Assessment and Mitigation

For KQ4, the body of evidence is rated as type 3 for the accuracy of risk assessment tools and insufficient for the effectiveness of use of risk assessment tools and mitigation strategies in reducing harms (six studies contributing; four from the original review plus two new studies). The 2014 AHRQ report included four studies (*88–91*) on the accuracy of risk assessment instruments, administered prior to opioid therapy initiation, for predicting opioid abuse or misuse. Results for the Opioid Risk Tool (ORT) (*89–91*) were extremely inconsistent; evidence for other risk assessment instruments was very sparse, and studies had serious methodological shortcomings. One additional fair-quality (*92*) and one poor-quality (*93*) study identified for this update compared the predictive accuracy of the ORT, the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), and the Brief Risk Interview.

For the ORT, sensitivity was 0.58 and 0.75 and specificity 0.54 and 0.86; for the SOAPP-R, sensitivity was 0.53 and 0.25 and specificity 0.62 and 0.73; and for the Brief Risk Interview, sensitivity was 0.73 and 0.83 and specificity 0.43 and 0.88. For the ORT, positive likelihood ratios ranged from noninformative (positive likelihood ratio close to 1) to moderately useful (positive likelihood ratio >5). The SOAPP-R was associated with noninformative likelihood ratios (estimates close to 1) in both studies.

No study evaluated the effectiveness of risk mitigation strategies (use of risk assessment instruments, opioid management plans, patient education, urine drug testing, use of PDMP data, use of monitoring instruments, more frequent monitoring intervals, pill counts, or use of abuse-deterrent formulations) for improving outcomes related to overdose, addiction, abuse, or misuse.

### Effects of Opioid Therapy for Acute Pain on Long-Term Use

For KQ5, the body of evidence is rated as type 3 (two new studies contributing). Two fair-quality retrospective cohort studies found opioid therapy prescribed for acute pain associated with greater likelihood of long-term use. One study evaluated opioid-naïve patients who had undergone low-risk surgery, such as cataract surgery and varicose vein stripping (*94*). Use of opioids within 7 days of surgery was associated with increased risk for use at 1 year. The other study found that among patients with a workers' compensation claim for acute low back pain, compared to patients who did not receive opioids early after injury (defined as use within 15 days following onset of pain), patients who did receive early opioids had an increased likelihood of receiving five or more opioid prescriptions 30–730 days following onset that increased with greater early exposure. Versus no early opioid use, the adjusted OR was 2.08 (95% CI = 1.55–2.78) for 1–140 MME/day and increased to 6.14 (95% confidence interval [CI] = 4.92–7.66) for ≥450 MME/day (*95*).

## Summary of the Contextual Evidence Review

### Primary Areas of Focus

Contextual evidence is complementary information that assists in translating the clinical research findings into recommendations. CDC conducted contextual evidence reviews on four topics to supplement the clinical evidence review findings:

- Effectiveness of nonpharmacologic (e.g., cognitive behavioral therapy [CBT], exercise therapy, interventional treatments, and multimodal pain treatment) and nonopioid pharmacologic treatments (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], antidepressants, and anticonvulsants), including studies of any duration.
- Benefits and harms of opioid therapy (including additional studies not included in the clinical evidence review, such as studies that were not restricted to patients with chronic pain, evaluated outcomes at any duration, performed ecological analyses, or used observational study designs other than cohort and case-cohort control studies) related to specific opioids, high-dose therapy, co-prescription with other controlled substances, duration of use, special populations, and potential usefulness of risk stratification/mitigation approaches, in addition to effectiveness of treatments associated with addressing potential harms of opioid therapy (opioid use disorder).
- Clinician and patient values and preferences related to opioids and medication risks, benefits, and use.
- Resource allocation including costs and economic efficiency of opioid therapy and risk mitigation strategies.

CDC also reviewed clinical guidelines that were relevant to opioid prescribing and could inform or complement the CDC recommendations under development (e.g., guidelines on nonpharmacologic and nonopioid pharmacologic treatments and guidelines with recommendations related to specific clinician actions such as urine drug testing or opioid tapering protocols).

## Contextual Evidence Review Methods

CDC conducted a contextual evidence review to assist in developing the recommendations by providing an assessment of the balance of benefits and harms, values and preferences, and cost, consistent with the GRADE approach. Given the public health urgency for developing opioid prescribing recommendations, a rapid review was required for the contextual evidence review for the current guideline. Rapid reviews are used when there is a need to streamline the systematic review process to obtain evidence quickly (*96*). Methods used to streamline the process include limiting searches by databases, years, and languages considered, and truncating quality assessment and data abstraction protocols. CDC conducted "rapid reviews" of the contextual evidence on nonpharmacologic and nonopioid pharmacologic treatments, benefits and harms, values and preferences, and resource allocation.

Detailed information about contextual evidence data sources and searches, inclusion criteria, study selection, and

data extraction and synthesis are provided in the Contextual Evidence Review (http://stacks.cdc.gov/view/cdc/38027). In brief, CDC conducted systematic literature searches to identify original studies, systematic reviews, and clinical guidelines, depending on the topic being searched. CDC also solicited publication referrals from subject matter experts. Given the need for a rapid review process, grey literature (e.g., literature by academia, organizations, or government in the forms of reports, documents, or proceedings not published by commercial publishers) was not systematically searched. Database sources, including MEDLINE, PsycINFO, the Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews, varied by topic. Multiple reviewers scanned study abstracts identified through the database searches and extracted relevant studies for review. CDC constructed narrative summaries and tables based on relevant articles that met inclusion criteria, which are provided in the Contextual Evidence Review (http://stacks.cdc.gov/view/cdc/38027).

Findings from the contextual reviews provide indirect evidence and should be interpreted accordingly. CDC did not formally rate the quality of evidence for the studies included in the contextual evidence review using the GRADE method. The studies that addressed benefits and harms, values and preferences, and resource allocation most often employed observational methods, used short follow-up periods, and evaluated selected samples. Therefore the strength of the evidence from these contextual review areas was considered to be low, comparable to type 3 or type 4 evidence. The quality of evidence for nonopioid pharmacologic and nonpharmacologic pain treatments was generally rated as moderate, comparable to type 2 evidence, in systematic reviews and clinical guidelines (e.g., for treatment of chronic neuropathic pain, low back pain, osteoarthritis, and fibromyalgia). Similarly, the quality of evidence on pharmacologic and psychosocial opioid use disorder treatment was generally rated as moderate, comparable to type 2 evidence, in systematic reviews and clinical guidelines.

## Summary of Findings for Contextual Areas

Full narrative reviews and tables that summarize key findings from the contextual evidence review are provided in the Contextual Evidence Review (http://stacks.cdc.gov/view/cdc/38027).

### Effectiveness of Nonpharmacologic and Nonopioid Pharmacologic Treatments

Several nonpharmacologic and nonopioid pharmacologic treatments have been shown to be effective in managing chronic pain in studies ranging in duration from 2 weeks to 6 months. For example, CBT that trains patients in behavioral techniques and helps patients modify situational factors and cognitive processes that exacerbate pain has small positive effects on disability and catastrophic thinking (*97*). Exercise therapy can help reduce pain and improve function in chronic low back pain (*98*), improve function and reduce pain in osteoarthritis of the knee (*99*) and hip (*100*), and improve well-being, fibromyalgia symptoms, and physical function in fibromyalgia (*101*). Multimodal and multidisciplinary therapies (e.g., therapies that combine exercise and related therapies with psychologically based approaches) can help reduce pain and improve function more effectively than single modalities (*102*,*103*). Nonopioid pharmacologic approaches used for pain include analgesics such as acetaminophen, NSAIDs, and cyclooxygenase 2 (COX-2) inhibitors; selected anticonvulsants; and selected antidepressants (particularly tricyclics and serotonin and norepinephrine reuptake inhibitors [SNRIs]). Multiple guidelines recommend acetaminophen as first-line pharmacotherapy for osteoarthritis (*104*–*109*) or for low back pain (*110*) but note that it should be avoided in liver failure and that dosage should be reduced in patients with hepatic insufficiency or a history of alcohol abuse (*109*). Although guidelines also recommend NSAIDs as first-line treatment for osteoarthritis or low back pain (*106*,*110*), NSAIDs and COX-2 inhibitors do have risks, including gastrointestinal bleeding or perforation as well as renal and cardiovascular risks (*111*). FDA has recently strengthened existing label warnings that NSAIDs increase risks for heart attack and stroke, including that these risks might increase with longer use or at higher doses (*112*). Several guidelines agree that first- and second-line drugs for neuropathic pain include anticonvulsants (gabapentin or pregabalin), tricyclic antidepressants, and SNRIs (*113*–*116*). Interventional approaches such as epidural injection for certain conditions (e.g., lumbar radiculopathy) can provide short-term improvement in pain (*117*–*119*). Epidural injection has been associated with rare but serious adverse events, including loss of vision, stroke, paralysis, and death (*120*).

### Benefits and Harms of Opioid Therapy

Balance between benefits and harms is a critical factor influencing the strength of clinical recommendations. In particular, CDC considered what is known from the epidemiology research about benefits and harms related to specific opioids and formulations, high dose therapy, co-prescription with other controlled substances, duration of use, special populations, and risk stratification and mitigation approaches. Additional information on benefits and harms of long-term opioid therapy from studies meeting rigorous selection criteria is provided in the clinical evidence review (e.g., see KQ2). CDC also considered the number of persons experiencing chronic pain, numbers potentially benefiting

from opioids, and numbers affected by opioid-related harms. A review of these data is presented in the background section of this document, with detailed information provided in the Contextual Evidence Review (http://stacks.cdc.gov/view/cdc/38027). Finally, CDC considered the effectiveness of treatments that addressed potential harms of opioid therapy (opioid use disorder).

Regarding specific opioids and formulations, as noted by FDA, there are serious risks of ER/LA opioids, and the indication for this class of medications is for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment in patients for whom other treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain (*121*). Time-scheduled opioid use was associated with substantially higher average daily opioid dosage than as-needed opioid use in one study (*122*). Methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for pain. Methadone has been found to account for as much as a third of opioid-related overdose deaths involving single or multiple drugs in states that participated in the Drug Abuse Warning Network, which was more than any opioid other than oxycodone, despite representing <2% of opioid prescriptions outside of opioid treatment programs in the United States; further, methadone was involved in twice as many single-drug deaths as any other prescription opioid (*123*).

Regarding high-dose therapy, several epidemiologic studies that were excluded from the clinical evidence review because patient samples were not restricted to patients with chronic pain also examined the association between opioid dosage and overdose risk (*23*,*24*,*124*–*126*). Consistent with the clinical evidence review, the contextual review found that opioid-related overdose risk is dose-dependent, with higher opioid dosages associated with increased overdose risk. Two of these studies (*23*,*24*), as well as the two studies in the clinical evidence review (*66*,*67*), evaluated similar MME/day dose ranges for association with overdose risk. In these four studies, compared with opioids prescribed at <20 MME/day, the odds of overdose among patients prescribed opioids for chronic nonmalignant pain were between 1.3 (*67*) and 1.9 (*24*) for dosages of 20 to <50 MME/day, between 1.9 (*67*) and 4.6 (*24*) for dosages of 50 to <100 MME/day, and between 2.0 (*67*) and 8.9 (*66*) for dosages of ≥100 MME/day. Compared with dosages of 1–<20 MME/day, absolute risk difference approximation for 50–<100 MME/day was 0.15% for fatal overdose (*24*) and 1.40% for any overdose (*66*), and for ≥100 MME/day was 0.25% for fatal overdose (*24*) and 4.04% for any overdose (*66*). A recent study of Veterans Health Administration patients with chronic pain found that patients who died of overdoses related to opioids were prescribed higher opioid dosages (mean: 98 MME/day; median: 60 MME/day) than controls (mean: 48 MME/day, median: 25 MME/day) (*127*). Finally, another recent study of overdose deaths among state residents with and without opioid prescriptions revealed that prescription opioid-related overdose mortality rates rose rapidly up to prescribed doses of 200 MME/day, after which the mortality rates continued to increase but grew more gradually (*128*). A listing of common opioid medications and their MME equivalents is provided (Table 2).

Regarding coprescription of opioids with benzodiazepines, epidemiologic studies suggest that concurrent use of benzodiazepines and opioids might put patients at greater risk for potentially fatal overdose. Three studies of fatal overdose deaths found evidence of concurrent benzodiazepine use in 31%–61% of decedents (*67*,*128*,*129*). In one of these studies (*67*), among decedents who received an opioid prescription, those whose deaths were related to opioids were more likely to have obtained opioids from multiple physicians and pharmacies than decedents whose deaths were not related to opioids.

Regarding duration of use, patients can experience tolerance and loss of effectiveness of opioids over time (*130*). Patients who do not experience clinically meaningful pain relief early in treatment (i.e., within 1 month) are unlikely to experience pain relief with longer-term use (*131*).

Regarding populations potentially at greater risk for harm, risk is greater for patients with sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders. Interpretation of clinical data on the effects of opioids on sleep-disordered breathing is difficult because of the types of study designs and methods employed, and there is no clear consensus regarding association with risk for developing obstructive sleep apnea syndrome (*132*). However, opioid therapy can decrease respiratory drive, a high percentage of patients on long-term opioid therapy have been reported to have an abnormal apnea-hypopnea index (*133*), opioid therapy can worsen central sleep apnea in obstructive sleep apnea patients, and it can cause further desaturation in obstructive sleep apnea patients not on continuous positive airway pressure (CPAP) (*31*). Reduced renal or hepatic function can result in greater peak effect and longer duration of action and reduce the dose at which respiratory depression and overdose occurs (*134*). Age-related changes in patients aged ≥65 years, such as reduced renal function and medication clearance, even in the absence of renal disease (*135*), result in a smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose. Older adults might also be at increased risk for falls and fractures related to opioids (*136*–*138*). Opioids used

in pregnancy can be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with birth defects, including neural tube defects (*139*,*140*), congenital heart defects (*140*), and gastroschisis (*140*); preterm delivery (*141*), poor fetal growth (*141*), and stillbirth (*141*). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome (*142*). Patients with mental health comorbidities and patients with histories of substance use disorders might be at higher risk than other patients for opioid use disorder (*62*,*143*,*144*). Recent analyses found that depressed patients were at higher risk for drug overdose than patients without depression, particularly at higher opioid dosages, although investigators were unable to distinguish unintentional overdose from suicide attempts (*145*). In case-control and case-cohort studies, substance abuse/dependence was more prevalent among patients experiencing overdose than among patients not experiencing overdose (12% versus 6% [*66*], 40% versus 10% [*24*], and 26% versus 9% [*23*]).

Regarding risk stratification approaches, limited evidence was found regarding benefits and harms. Potential benefits of PDMPs and urine drug testing include the ability to identify patients who might be at higher risk for opioid overdose or opioid use disorder, and help determine which patients will benefit from greater caution and increased monitoring or interventions when risk factors are present. For example, one study found that most fatal overdoses could be identified retrospectively on the basis of two pieces of information, multiple prescribers and high total daily opioid dosage, both important risk factors for overdose (*124*,*146*) that are available to prescribers in the PDMP (*124*). However, limited evaluation of PDMPs at the state level has revealed mixed effects on changes in prescribing and mortality outcomes (*28*). Potential harms of risk stratification include underestimation of risks of opioid therapy when screening tools are not adequately sensitive, as well as potential overestimation of risk, which could lead to inappropriate clinical decisions.

Regarding risk mitigation approaches, limited evidence was found regarding benefits and harms. Although no studies were found to examine prescribing of naloxone with opioid pain medication in primary care settings, naloxone distribution through community-based programs providing prevention services for substance users has been demonstrated to be associated with decreased risk for opioid overdose death at the community level (*147*).

Concerns have been raised that prescribing changes such as dose reduction might be associated with unintended negative consequences, such as patients seeking heroin or other illicitly obtained opioids (*148*) or interference with appropriate pain treatment (*149*). With the exception of a study noting an association between an abuse-deterrent formulation of OxyContin and heroin use, showing that some patients in qualitative interviews reported switching to another opioid, including heroin, for many reasons, including cost and availability as well as ease of use (*150*), CDC did not identify studies evaluating these potential outcomes.

Finally, regarding the effectiveness of opioid use disorder treatments, methadone and buprenorphine for opioid use disorder have been found to increase retention in treatment and to decrease illicit opioid use among patients with opioid use disorder involving heroin (*151*–*153*). Although findings are mixed, some studies suggest that effectiveness is enhanced when psychosocial treatments (e.g., contingency management, community reinforcement, psychotherapeutic counseling, and family therapy) are used in conjunction with medication-assisted therapy; for example, by reducing opioid misuse and increasing retention during maintenance therapy, and improving compliance after detoxification (*154*,*155*).

## Clinician and Patient Values and Preferences

Clinician and patient values and preferences can inform how benefits and harms of long-term opioid therapy are weighted and estimate the effort and resources required to effectively provide implementation support. Many physicians lack confidence in their ability to prescribe opioids safely (*156*), to predict (*157*) or detect (*158*) prescription drug abuse, and to discuss abuse with their patients (*158*). Although clinicians have reported favorable beliefs and attitudes about improvements in pain and quality of life attributed to opioids (*159*), most consider prescription drug abuse to be a "moderate" or "big" problem in their community, and large proportions are "very" concerned about opioid addiction (55%) and death (48%) (*160*). Clinicians do not consistently use practices intended to decrease the risk for misuse, such as PDMPs (*161*,*162*), urine drug testing (*163*), and opioid treatment agreements (*164*). This is likely due in part to challenges related to registering for PDMP access and logging into the PDMP (which can interrupt normal clinical workflow if data are not integrated into electronic health record systems) (*165*), competing clinical demands, perceived inadequate time to discuss the rationale for urine drug testing and to order confirmatory testing, and feeling unprepared to interpret and address results (*166*).

Many patients do not have an opinion about "opioids" or know what this term means (*167*). Most are familiar with the term "narcotics." About a third associated "narcotics" with addiction or abuse, and about half feared "addiction" from long-term "narcotic" use (*168*). Most patients taking opioids experience side effects (73% of patients taking hydrocodone for noncancer pain [*11*], 96% of patients taking opioids for chronic pain [*12*]), and side effects, rather than pain relief,

have been found to explain most of the variation in patients' preferences related to taking opioids (*12*). For example, patients taking hydrocodone for noncancer pain commonly reported side effects including dizziness, headache, fatigue, drowsiness, nausea, vomiting, and constipation (*11*). Patients with chronic pain in focus groups emphasized effectiveness of goal setting for increasing motivation and functioning (*168*). Patients taking high dosages report reliance on opioids despite ambivalence about their benefits (*169*) and regardless of pain reduction, reported problems, concerns, side effects, or perceived helpfulness (*13*).

### Resource Allocation

Resource allocation (cost) is an important consideration in understanding the feasibility of clinical recommendations. CDC searched for evidence on opioid therapy compared with other treatments; costs of misuse, abuse, and overdose from prescription opioids; and costs of specific risk mitigation strategies (e.g., urine drug testing). Yearly direct and indirect costs related to prescription opioids have been estimated (based on studies published since 2010) to be $53.4 billion for nonmedical use of prescription opioids (*170*); $55.7 billion for abuse, dependence (i.e., opioid use disorder), and misuse of prescription opioids (*171*); and $20.4 billion for direct and indirect costs related to opioid-related overdose alone (*172*). In 2012, total expenses for outpatient prescription opioids were estimated at $9.0 billion, an increase of 120% from 2002 (*173*). Although there are perceptions that opioid therapy for chronic pain is less expensive than more time-intensive nonpharmacologic management approaches, many pain treatments, including acetaminophen, NSAIDs, tricyclic antidepressants, and massage therapy, are associated with lower mean and median annual costs compared with opioid therapy (*174*). COX-2 inhibitors, SNRIs, anticonvulsants, topical analgesics, physical therapy, and CBT are also associated with lower median annual costs compared with opioid therapy (*174*). Limited information was found on costs of strategies to decrease risks associated with opioid therapy; however, urine drug testing, including screening and confirmatory tests, has been estimated to cost $211–$363 per test (*175*).

## Recommendations

The recommendations are grouped into three areas for consideration:

- Determining when to initiate or continue opioids for chronic pain.
- Opioid selection, dosage, duration, follow-up, and discontinuation.
- Assessing risk and addressing harms of opioid use.

There are 12 recommendations (Box 1). Each recommendation is followed by a rationale for the recommendation, with considerations for implementation noted. In accordance with the ACIP GRADE process, CDC based the recommendations on consideration of the clinical evidence, contextual evidence (including benefits and harms, values and preferences, resource allocation), and expert opinion. For each recommendation statement, CDC notes the recommendation category (A or B) and the type of the evidence (1, 2, 3, or 4) supporting the statement (Box 2). Expert opinion is reflected within each of the recommendation rationales. While there was not an attempt to reach consensus among experts, experts from the Core Expert Group and from the Opioid Guideline Workgroup ("experts") expressed overall, general support for all recommendations. Where differences in expert opinion emerged for detailed actions within the clinical recommendations or for implementation considerations, CDC notes the differences of opinion in the supporting rationale statements.

Category A recommendations indicate that most patients should receive the recommended course of action; category B recommendations indicate that different choices will be appropriate for different patients, requiring clinicians to help patients arrive at a decision consistent with patient values and preferences and specific clinical situations. Consistent with the ACIP (*47*) and GRADE process (*48*), category A recommendations were made, even with type 3 and 4 evidence, when there was broad agreement that the advantages of a clinical action greatly outweighed the disadvantages based on a consideration of benefits and harms, values and preferences, and resource allocation. Category B recommendations were made when there was broad agreement that the advantages and disadvantages of a clinical action were more balanced, but advantages were significant enough to warrant a recommendation. All recommendations are category A recommendations, with the exception of recommendation 10, which is rated as category B. Recommendations were associated with a range of evidence types, from type 2 to type 4.

In summary, the categorization of recommendations was based on the following assessment:

- No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least 1 year later (with most placebo-controlled randomized trials ≤6 weeks in duration).
- Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury).
- Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic treatments compared with long-term opioid therapy, with less harm.

**BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care**

**Determining When to Initiate or Continue Opioids for Chronic Pain**

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

**Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation**

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

**Assessing Risk and Addressing Harms of Opioid Use**

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

**BOX 2. Interpretation of recommendation categories and evidence type**

**Recommendation Categories**

Based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation (cost).

**Category A recommendation**: Applies to all persons; most patients should receive the recommended course of action.

**Category B recommendation**: Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

**Evidence Type**

Based on study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects.

**Type 1 evidence**: Randomized clinical trials or overwhelming evidence from observational studies.

**Type 2 evidence**: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.

**Type 3 evidence**: Observational studies or randomized clinical trials with notable limitations.

**Type 4 evidence**: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

## Determining When to Initiate or Continue Opioids for Chronic Pain

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).**

Patients with pain should receive treatment that provides the greatest benefits relative to risks. The contextual evidence review found that many nonpharmacologic therapies, including physical therapy, weight loss for knee osteoarthritis, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain. There is high-quality evidence that exercise therapy (a prominent modality in physical therapy) for hip (*100*) or knee (*99*) osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2–6 months. Previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (*176*). Exercise therapy also can help reduce pain and improve function in low back pain and can improve global well-being and physical function in fibromyalgia (*98*,*101*). Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches (e.g., psychological therapies with exercise) can reduce long-term pain and disability compared with usual care and compared with physical treatments (e.g., exercise) alone. Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients. Interventional approaches such as arthrocentesis and intraarticular glucocorticoid injection for pain associated with rheumatoid arthritis (*117*) or osteoarthritis (*118*) and subacromial corticosteroid injection for rotator cuff disease (*119*) can provide short-term improvement in pain and function. Evidence is insufficient to determine the extent to which repeated glucocorticoid injection increases potential risks such as articular cartilage changes (in osteoarthritis) and sepsis (*118*). Serious adverse events are rare but have been reported with epidural injection (*120*).

Several nonopioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are effective for chronic pain. In particular, acetaminophen and NSAIDs can be useful for arthritis and low back pain. Selected anticonvulsants such as pregabalin and gabapentin can improve pain in diabetic neuropathy and post-herpetic neuralgia (contextual evidence review). Pregabalin, gabapentin, and carbamazepine are FDA-approved for treatment of certain neuropathic pain conditions, and pregabalin is FDA approved for fibromyalgia management. In patients with or without depression, tricyclic antidepressants and SNRIs provide effective analgesia for neuropathic pain conditions including diabetic neuropathy and post-herpetic neuralgia, often at lower dosages and with a shorter time to onset of effect than for treatment of depression (see contextual evidence review). Tricyclics and SNRIs can also relieve fibromyalgia symptoms. The SNRI duloxetine is FDA-approved for the treatment of diabetic neuropathy and fibromyalgia. Because patients with chronic pain often suffer from concurrent depression (*144*), and depression can exacerbate physical symptoms including pain (*177*), patients with co-occurring pain and depression are especially likely to benefit from antidepressant medication (see Recommendation 8). Nonopioid pharmacologic therapies

are not generally associated with substance use disorder, and the numbers of fatal overdoses associated with nonopioid medications are a fraction of those associated with opioid medications (contextual evidence review). For example, acetaminophen, NSAIDs, and opioid pain medication were involved in 881, 228, and 16,651 pharmaceutical overdose deaths in the United States in 2010 (*178*). However, nonopioid pharmacologic therapies are associated with certain risks, particularly in older patients, pregnant patients, and patients with certain co-morbidities such as cardiovascular, renal, gastrointestinal, and liver disease (see contextual evidence review). For example, acetaminophen can be hepatotoxic at dosages of >3–4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease (*109*). NSAID use has been associated with gastritis, peptic ulcer disease, cardiovascular events (*111*,*112*), and fluid retention, and most NSAIDs (choline magnesium trilisate and selective COX-2 inhibitors are exceptions) interfere with platelet aggregation (*179*). Clinicians should review FDA-approved labeling including boxed warnings before initiating treatment with any pharmacologic therapy.

Although opioids can reduce pain during short-term use, the clinical evidence review found insufficient evidence to determine whether pain relief is sustained and whether function or quality of life improves with long-term opioid therapy (KQ1). While benefits for pain relief, function, and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are clearer and significant. Based on the clinical evidence review, long-term opioid use for chronic pain is associated with serious risks including increased risk for opioid use disorder, overdose, myocardial infarction, and motor vehicle injury (KQ2). At a population level, more than 165,000 persons in the United States have died from opioid pain-medication-related overdoses since 1999 (see Contextual Evidence Review).

Integrated pain management requires coordination of medical, psychological, and social aspects of health care and includes primary care, mental health care, and specialist services when needed (*180*). Nonpharmacologic physical and psychological treatments such as exercise and CBT are approaches that encourage active patient participation in the care plan, address the effects of pain in the patient's life, and can result in sustained improvements in pain and function without apparent risks. Despite this, these therapies are not always or fully covered by insurance, and access and cost can be barriers for patients. For many patients, aspects of these approaches can be used even when there is limited access to specialty care. For example, previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (*176*) and maintenance of activity for patients with low back pain (*110*). A randomized trial found no difference in reduced chronic low back pain intensity, frequency or disability between patients assigned to relatively low-cost group aerobics and individual physiotherapy or muscle reconditioning sessions (*181*). Low-cost options to integrate exercise include brisk walking in public spaces or use of public recreation facilities for group exercise. CBT addresses psychosocial contributors to pain and improves function (*97*). Primary care clinicians can integrate elements of a cognitive behavioral approach into their practice by encouraging patients to take an active role in the care plan, by supporting patients in engaging in beneficial but potentially anxiety-provoking activities, such as exercise (*179*), or by providing education in relaxation techniques and coping strategies. In many locations, there are free or low-cost patient support, self-help, and educational community-based programs that can provide stress reduction and other mental health benefits. Patients with more entrenched anxiety or fear related to pain, or other significant psychological distress, can be referred for formal therapy with a mental health specialist (e.g., psychologist, psychiatrist, clinical social worker). Multimodal therapies should be considered for patients not responding to single-modality therapy, and combinations should be tailored depending on patient needs, cost, and convenience.

To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis. Detailed recommendations on diagnosis are provided in other guidelines (*110*,*179*), but evaluation should generally include a focused history, including history and characteristics of pain and potentially contributing factors (e.g., function, psychosocial stressors, sleep) and physical exam, with imaging or other diagnostic testing only if indicated (e.g., if severe or progressive neurologic deficits are present or if serious underlying conditions are suspected) (*110*,*179*). For complex pain syndromes, pain specialty consultation can be considered to assist with diagnosis as well as management. Diagnosis can help identify disease-specific interventions to reverse or ameliorate pain; for example, improving glucose control to prevent progression of diabetic neuropathy; immune-modulating agents for rheumatoid arthritis; physical or occupational therapy to address posture, muscle weakness, or repetitive occupational motions that contribute to musculoskeletal pain; or surgical intervention to relieve mechanical/compressive pain (*179*). The underlying mechanism for most pain syndromes can be categorized as neuropathic (e.g., diabetic neuropathy, postherpetic neuralgia, fibromyalgia), or nociceptive (e.g., osteoarthritis, muscular back pain). The diagnosis and pathophysiologic mechanism of pain have implications for symptomatic pain treatment with medication. For example, evidence is limited or insufficient

for improved pain or function with long-term use of opioids for several chronic pain conditions for which opioids are commonly prescribed, such as low back pain (*182*), headache (*183*), and fibromyalgia (*184*). Although NSAIDs can be used for exacerbations of nociceptive pain, other medications (e.g., tricyclics, selected anticonvulsants, or transdermal lidocaine) generally are recommended for neuropathic pain. In addition, improvement of neuropathic pain can begin weeks or longer after symptomatic treatment is initiated (*179*). Medications should be used only after assessment and determination that expected benefits outweigh risks given patient-specific factors. For example, clinicians should consider falls risk when selecting and dosing potentially sedating medications such as tricyclics, anticonvulsants, or opioids, and should weigh risks and benefits of use, dose, and duration of NSAIDs when treating older adults as well as patients with hypertension, renal insufficiency, or heart failure, or those with risk for peptic ulcer disease or cardiovascular disease. Some guidelines recommend topical NSAIDs for localized osteoarthritis (e.g., knee osteoarthritis) over oral NSAIDs in patients aged ≥75 years to minimize systemic effects (*176*).

Experts agreed that opioids should not be considered first-line or routine therapy for chronic pain (i.e., pain continuing or expected to continue >3 months or past the time of normal tissue healing) outside of active cancer, palliative, and end-of-life care, given small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harms; although evidence on long-term benefits of nonopioid therapies is also limited, these therapies are also associated with short-term benefits, and risks are much lower. This does not mean that patients should be required to sequentially "fail" nonpharmacologic and nonopioid pharmacologic therapy before proceeding to opioid therapy. Rather, expected benefits specific to the clinical context should be weighed against risks before initiating therapy. In some clinical contexts (e.g., headache or fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used. In other situations (e.g., serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort), opioids might be appropriate regardless of previous therapies used. In addition, when opioid pain medication is used, it is more likely to be effective if integrated with nonpharmacologic therapy. Nonpharmacologic approaches such as exercise and CBT should be used to reduce pain and improve function in patients with chronic pain. Nonopioid pharmacologic therapy should be used when benefits outweigh risks and should be combined with nonpharmacologic therapy to reduce pain and improve function. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate, to provide greater benefits to patients in improving pain and function.

2. **Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).**

The clinical evidence review found insufficient evidence to determine long-term benefits of opioid therapy for chronic pain and found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. In addition, studies on currently available risk assessment instruments were sparse and showed inconsistent results (KQ4). The clinical evidence review for the current guideline considered studies with outcomes examined at ≥1 year that compared opioid use versus nonuse or placebo. Studies of opioid therapy for chronic pain that did not have a nonopioid control group have found that although many patients discontinue opioid therapy for chronic noncancer pain due to adverse effects or insufficient pain relief, there is weak evidence that patients who are able to continue opioid therapy for at least 6 months can experience clinically significant pain relief and insufficient evidence that function or quality of life improves (*185*). These findings suggest that it is very difficult for clinicians to predict whether benefits of opioids for chronic pain will outweigh risks of ongoing treatment for individual patients. Opioid therapy should not be initiated without consideration of an "exit strategy" to be used if the therapy is unsuccessful.

Experts agreed that before opioid therapy is initiated for chronic pain outside of active cancer, palliative, and end-of-life care, clinicians should determine how effectiveness will be evaluated and should establish treatment goals with patients. Because the line between acute pain and initial chronic pain is not always clear, it might be difficult for clinicians to determine when they are initiating opioids for chronic pain rather than treating acute pain. Pain lasting longer than 3 months or past the time of normal tissue healing (which could be substantially shorter than 3 months, depending on the condition) is generally no longer considered acute. However, establishing treatment goals with a patient who has already received opioid therapy for 3 months would defer this discussion well past the point of

initiation of opioid therapy for chronic pain. Clinicians often write prescriptions for long-term use in 30-day increments, and opioid prescriptions written for ≥30 days are likely to represent initiation or continuation of long-term opioid therapy. Before writing an opioid prescription for ≥30 days, clinicians should establish treatment goals with patients. Clinicians seeing new patients already receiving opioids should establish treatment goals for continued opioid therapy. Although the clinical evidence review did not find studies evaluating the effectiveness of written agreements or treatment plans (KQ4), clinicians and patients who set a plan in advance will clarify expectations regarding how opioids will be prescribed and monitored, as well as situations in which opioids will be discontinued or doses tapered (e.g., if treatment goals are not met, opioids are no longer needed, or adverse events put the patient at risk) to improve patient safety.

Experts thought that goals should include improvement in both pain relief and function (and therefore in quality of life). However, there are some clinical circumstances under which reductions in pain without improvement in physical function might be a more realistic goal (e.g., diseases typically associated with progressive functional impairment or catastrophic injuries such as spinal cord trauma). Experts noted that function can include emotional and social as well as physical dimensions. In addition, experts emphasized that mood has important interactions with pain and function. Experts agreed that clinicians may use validated instruments such as the three-item "Pain average, interference with Enjoyment of life, and interference with General activity" (PEG) Assessment Scale (*186*) to track patient outcomes. Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function (*187*). Monitoring progress toward patient-centered functional goals (e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities) can also contribute to the assessment of functional improvement. Clinicians should use these goals in assessing benefits of opioid therapy for individual patients and in weighing benefits against risks of continued opioid therapy (see Recommendation 7, including recommended intervals for follow-up). Because depression, anxiety, and other psychological co-morbidities often coexist with and can interfere with resolution of pain, clinicians should use validated instruments to assess for these conditions (see Recommendation 8) and ensure that treatment for these conditions is optimized. If patients receiving opioid therapy for chronic pain do not experience meaningful improvements in both pain and function compared with prior to initiation of opioid therapy, clinicians should consider working with patients to taper and discontinue opioids (see Recommendation 7) and should use nonpharmacologic and nonopioid pharmacologic approaches to pain management (see Recommendation 1).

3. **Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type: 3).**

The clinical evidence review did not find studies evaluating effectiveness of patient education or opioid treatment plans as risk-mitigation strategies (KQ4). However, the contextual evidence review found that many patients lack information about opioids and identified concerns that some clinicians miss opportunities to effectively communicate about safety. Given the substantial evidence gaps on opioids, uncertain benefits of long-term use, and potential for serious harms, patient education and discussion before starting opioid therapy are critical so that patient preferences and values can be understood and used to inform clinical decisions. Experts agreed that essential elements to communicate to patients before starting and periodically during opioid therapy include realistic expected benefits, common and serious harms, and expectations for clinician and patient responsibilities to mitigate risks of opioid therapy.

Clinicians should involve patients in decisions about whether to start or continue opioid therapy. Given potentially serious risks of long-term opioid therapy, clinicians should ensure that patients are aware of potential benefits of, harms of, and alternatives to opioids before starting or continuing opioid therapy. Clinicians are encouraged to have open and honest discussions with patients to inform mutual decisions about whether to start or continue opioid therapy. Important considerations include the following:

- Be explicit and realistic about expected benefits of opioids, explaining that while opioids can reduce pain during short-term use, there is no good evidence that opioids improve pain or function with long-term use, and that complete relief of pain is unlikely (clinical evidence review, KQ1).
- Emphasize improvement in function as a primary goal and that function can improve even when pain is still present.
- Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations.
- Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase

hydration and fiber intake and to maintain or increase physical activity. Stool softeners or laxatives might be needed.
- Discuss effects that opioids might have on ability to safely operate a vehicle, particularly when opioids are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently.
- Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often.
- Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opioids.
- Discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient, and that young children are susceptible to unintentional ingestion. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (*188*).
- Discuss the importance of periodic reassessment to ensure that opioids are helping to meet patient goals and to allow opportunities for opioid discontinuation and consideration of additional nonpharmacologic or nonopioid pharmacologic treatment options if opioids are not effective or are harmful.
- Discuss planned use of precautions to reduce risks, including use of prescription drug monitoring program information (see Recommendation 9) and urine drug testing (see Recommendation 10). Consider including discussion of naloxone use for overdose reversal (see Recommendation 8).
- Consider whether cognitive limitations might interfere with management of opioid therapy (for older adults in particular) and, if so, determine whether a caregiver can responsibly co-manage medication therapy. Discuss the importance of reassessing safer medication use with both the patient and caregiver.

Given the possibility that benefits of opioid therapy might diminish or that risks might become more prominent over time, it is important that clinicians review expected benefits and risks of continued opioid therapy with patients periodically, at least every 3 months (see Recommendation 7).

## Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

**4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).**

ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine. The clinical evidence review found a fair-quality study showing a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids (*77*). The clinical evidence review did not find evidence that continuous, time-scheduled use of ER/LA opioids is more effective or safer than intermittent use of immediate-release opioids or that time-scheduled use of ER/LA opioids reduces risks for opioid misuse or addiction (KQ3).

In 2014, the FDA modified the labeling for ER/LA opioid pain medications, noting serious risks and recommending that ER/LA opioids be reserved for "management of pain severe enough to require daily, around-the-clock, long-term opioid treatment" when "alternative treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain" and not used as "as needed" pain relievers (*121*). FDA has also noted that some ER/LA opioids are only appropriate for opioid-tolerant patients, defined as patients who have received certain dosages of opioids (e.g., 60 mg daily of oral morphine, 30 mg daily of oral oxycodone, or equianalgesic dosages of other opioids) for at least 1 week (*189*). Time-scheduled opioid use can be associated with greater total average daily opioid dosage compared with intermittent, as-needed opioid use (contextual evidence review). In addition, experts indicated that there was not enough evidence to determine the safety of using immediate-release opioids for breakthrough pain when ER/LA opioids are used for chronic pain outside of active cancer pain, palliative care, or end-of-life care, and that this practice might be associated with dose escalation.

Abuse-deterrent technologies have been employed to prevent manipulation intended to defeat extended-release properties of ER/LA opioids and to prevent opioid use by unintended routes of administration, such as injection of oral opioids. As indicated in FDA guidance for industry on evaluation and labeling of abuse-deterrent opioids (*190*), although abuse-deterrent technologies are expected to make manipulation of opioids more difficult or less rewarding, they do not prevent

opioid abuse through oral intake, the most common route of opioid abuse, and can still be abused by nonoral routes. The "abuse-deterrent" label does not indicate that there is no risk for abuse. No studies were found in the clinical evidence review assessing the effectiveness of abuse-deterrent technologies as a risk mitigation strategy for deterring or preventing abuse. In addition, abuse-deterrent technologies do not prevent unintentional overdose through oral intake. Experts agreed that recommendations could not be offered at this time related to use of abuse-deterrent formulations.

In comparing different ER/LA formulations, the clinical evidence review found inconsistent results for overdose risk with methadone versus other ER/LA opioids used for chronic pain (KQ3). The contextual evidence review found that methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for chronic pain. In addition, methadone is associated with cardiac arrhythmias along with QT prolongation on the electrocardiogram, and it has complicated pharmacokinetics and pharmacodynamics, including a long and variable half-life and peak respiratory depressant effect occurring later and lasting longer than peak analgesic effect. Experts noted that the pharmacodynamics of methadone are subject to more inter-individual variability than other opioids. In regard to other ER/LA opioid formulations, experts noted that the absorption and pharmacodynamics of transdermal fentanyl are complex, with gradually increasing serum concentration during the first part of the 72-hour dosing interval, as well as variable absorption based on factors such as external heat. In addition, the dosing of transdermal fentanyl in mcg/hour, which is not typical for a drug used by outpatients, can be confusing. Experts thought that these complexities might increase the risk for fatal overdose when methadone or transdermal fentanyl is prescribed to a patient who has not used it previously or by clinicians who are not familiar with its effects.

Experts agreed that for patients not already receiving opioids, clinicians should not initiate opioid treatment with ER/LA opioids and should not prescribe ER/LA opioids for intermittent use. ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least 1 week. When changing to an ER/LA opioid for a patient previously receiving a different immediate-release opioid, clinicians should consult product labeling and reduce total daily dosage to account for incomplete opioid cross-tolerance. Clinicians should use additional caution with ER/LA opioids and consider a longer dosing interval when prescribing to patients with renal or hepatic dysfunction because decreased clearance of drugs among these patients can lead to accumulation of drugs to toxic levels and persistence in the body for longer durations. Although there might be situations in which clinicians need to prescribe immediate-release and ER/LA opioids together (e.g., transitioning patients from ER/LA opioids to immediate-release opioids by temporarily using lower dosages of both), in general, avoiding the use of immediate-release opioids in combination with ER/LA opioids is preferable, given potentially increased risk and diminishing returns of such an approach for chronic pain.

When an ER/LA opioid is prescribed, using one with predictable pharmacokinetics and pharmacodynamics is preferred to minimize unintentional overdose risk. In particular, unusual characteristics of methadone and of transdermal fentanyl make safe prescribing of these medications for pain especially challenging.

- Methadone should not be the first choice for an ER/LA opioid. Only clinicians who are familiar with methadone's unique risk profile and who are prepared to educate and closely monitor their patients, including risk assessment for QT prolongation and consideration of electrocardiographic monitoring, should consider prescribing methadone for pain. A clinical practice guideline that contains further guidance regarding methadone prescribing for pain has been published previously (*191*).
- Because dosing effects of transdermal fentanyl are often misunderstood by both clinicians and patients, only clinicians who are familiar with the dosing and absorption properties of transdermal fentanyl and are prepared to educate their patients about its use should consider prescribing it.

5. **When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (recommendation category: A, evidence type: 3).**

Benefits of high-dose opioids for chronic pain are not established. The clinical evidence review found only one study (*84*) addressing effectiveness of dose titration for outcomes related to pain control, function, and quality of life (KQ3). This randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy and maintenance of current dosage. (These groups were prescribed average dosages of 52 and 40 MME/day, respectively, at the end of the trial.) At the same time, risks for serious harms

related to opioid therapy increase at higher opioid dosage. The clinical evidence review found that higher opioid dosages are associated with increased risks for motor vehicle injury, opioid use disorder, and overdose (KQ2). The clinical and contextual evidence reviews found that opioid overdose risk increases in a dose-response manner, that dosages of 50–<100 MME/day have been found to increase risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1–<20 MME/day, and that dosages ≥100 MME/day are associated with increased risks of overdose 2.0–8.9 times the risk at 1–<20 MME/day. In a national sample of Veterans Health Administration patients with chronic pain who were prescribed opioids, mean prescribed opioid dosage among patients who died from opioid overdose was 98 MME (median 60 MME) compared with mean prescribed opioid dosage of 48 MME (median 25 MME) among patients not experiencing fatal overdose (*127*).

The contextual evidence review found that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages <50 MME/day would likely reduce risk among a large proportion of patients who would experience fatal overdose at higher prescribed dosages. Experts agreed that lower dosages of opioids reduce the risk for overdose, but that a single dosage threshold for safe opioid use could not be identified. Experts noted that daily opioid dosages close to or greater than 100 MME/day are associated with significant risks, that dosages <50 MME/day are safer than dosages of 50–100 MME/day, and that dosages <20 MME/day are safer than dosages of 20–50 MME/day. One expert thought that a specific dosage at which the benefit/risk ratio of opioid therapy decreases could not be identified. Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function and that clinicians should carefully reassess evidence of individual benefits and risks when considering increasing opioid dosages to ≥50 MME/day. Most experts also agreed that opioid dosages should not be increased to ≥90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks.

When opioids are used for chronic pain outside of active cancer, palliative, and end-of-life care, clinicians should start opioids at the lowest possible effective dosage (the lowest starting dosage on product labeling for patients not already taking opioids and according to product labeling guidance regarding tolerance for patients already taking opioids). Clinicians should use additional caution when initiating opioids for patients aged ≥65 years and for patients with renal or hepatic insufficiency because decreased clearance of drugs in these patients can result in accumulation of drugs to toxic levels. Clinicians should use caution when increasing opioid dosages and increase dosage by the smallest practical amount because overdose risk increases with increases in opioid dosage. Although there is limited evidence to recommend specific intervals for dosage titration, a previous guideline recommended waiting at least five half-lives before increasing dosage and waiting at least a week before increasing dosage of methadone to make sure that full effects of the previous dosage are evident (*31*). Clinicians should re-evaluate patients after increasing dosage for changes in pain, function, and risk for harm (see Recommendation 7). Before increasing total opioid dosage to ≥50 MME/day, clinicians should reassess whether opioid treatment is meeting the patient's treatment goals (see Recommendation 2). If a patient's opioid dosage for all sources of opioids combined reaches or exceeds 50 MME/day, clinicians should implement additional precautions, including increased frequency of follow-up (see Recommendation 7) and considering offering naloxone and overdose prevention education to both patients and the patients' household members (see Recommendation 8). Clinicians should avoid increasing opioid dosages to ≥90 MME/day or should carefully justify a decision to increase dosage to ≥90 MME/day based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to harms as dosages approach 90 MME/day, other treatments and effectiveness, and recommendations based on consultation with pain specialists. If patients do not experience improvement in pain and function at ≥90 MME/day, or if there are escalating dosage requirements, clinicians should discuss other approaches to pain management with the patient, consider working with patients to taper opioids to a lower dosage or to taper and discontinue opioids (see Recommendation 7), and consider consulting a pain specialist. Some states require clinicians to implement clinical protocols at specific dosage levels. For example, before increasing long-term opioid therapy dosage to >120 MME/day, clinicians in Washington state must obtain consultation from a pain specialist who agrees that this is indicated and appropriate (*30*). Clinicians should be aware of rules related to MME thresholds and associated clinical protocols established by their states.

Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians, might consider the possibility of opioid dosage reduction to be anxiety-provoking, and tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence. However, these patients should be offered the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk. Clinicians should explain in a nonjudgmental manner to patients already taking high opioid dosages (≥90 MME/day) that there is

now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages. Clinicians should empathically review benefits and risks of continued high-dosage opioid therapy and should offer to work with the patient to taper opioids to safer dosages. For patients who agree to taper opioids to lower dosages, clinicians should collaborate with the patient on a tapering plan (see Recommendation 7). Experts noted that patients tapering opioids after taking them for years might require very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages. Clinicians should remain alert to signs of anxiety, depression, and opioid use disorder (see Recommendations 8 and 12) that might be unmasked by an opioid taper and arrange for management of these co-morbidities. For patients agreeing to taper to lower opioid dosages as well as for those remaining on high opioid dosages, clinicians should establish goals with the patient for continued opioid therapy (see Recommendation 2), maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 1), and consider consulting a pain specialist as needed to assist with pain management.

6. **Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4).**

The clinical evidence review found that opioid use for acute pain (i.e., pain with abrupt onset and caused by an injury or other process that is not ongoing) is associated with long-term opioid use, and that a greater amount of early opioid exposure is associated with greater risk for long-term use (KQ5). Several guidelines on opioid prescribing for acute pain from emergency departments (*192–194*) and other settings (*195*,*196*) have recommended prescribing ≤3 days of opioids in most cases, whereas others have recommended ≤7 days (*197*) or <14 days (*30*). Because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days (contextual evidence review), limiting days of opioids prescribed also should minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms. Experts noted that more than a few days of exposure to opioids significantly increases hazards, that each day of unnecessary opioid use increases likelihood of physical dependence without adding benefit, and that prescriptions with fewer days' supply will minimize the number of pills available for unintentional or intentional diversion.

Experts agreed that when opioids are needed for acute pain, clinicians should prescribe opioids at the lowest effective dose and for no longer than the expected duration of pain severe enough to require opioids to minimize unintentional initiation of long-term opioid use. The lowest effective dose can be determined using product labeling as a starting point with calibration as needed based on the severity of pain and on other clinical factors such as renal or hepatic insufficiency (see Recommendation 8). Experts thought, based on clinical experience regarding anticipated duration of pain severe enough to require an opioid, that in most cases of acute pain not related to surgery or trauma, a ≤3 days' supply of opioids will be sufficient. For example, in one study of the course of acute low back pain (not associated with malignancies, infections, spondylarthropathies, fractures, or neurological signs) in a primary care setting, there was a large decrease in pain until the fourth day after treatment with paracetamol, with smaller decreases thereafter (*198*). Some experts thought that because some types of acute pain might require more than 3 days of opioid treatment, it would be appropriate to recommend a range of ≤3–5 days or ≤3–7 days when opioids are needed. Some experts thought that a range including 7 days was too long given the expected course of severe acute pain for most acute pain syndromes seen in primary care.

Acute pain can often be managed without opioids. It is important to evaluate the patient for reversible causes of pain, for underlying etiologies with potentially serious sequelae, and to determine appropriate treatment. When the diagnosis and severity of nontraumatic, nonsurgical acute pain are reasonably assumed to warrant the use of opioids, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids, often 3 days or less, unless circumstances clearly warrant additional opioid therapy. More than 7 days will rarely be needed. Opioid treatment for post-surgical pain is outside the scope of this guideline but has been addressed elsewhere (*30*). Clinicians should not prescribe additional opioids to patients "just in case" pain continues longer than expected. Clinicians should re-evaluate the subset of patients who experience severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly. Given longer half-lives and longer duration of effects (e.g., respiratory depression) with ER/LA opioids such as methadone, fentanyl patches, or extended release versions of opioids such as oxycodone, oxymorphone, or morphine, clinicians should not prescribe ER/LA opioids for the treatment of acute pain.

7. **Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).**

Although the clinical evidence review did not find studies evaluating the effectiveness of more frequent monitoring intervals (KQ4), it did find that continuing opioid therapy for 3 months substantially increases risk for opioid use disorder (KQ2); therefore, follow-up earlier than 3 months might be necessary to provide the greatest opportunity to prevent the development of opioid use disorder. In addition, risk for overdose associated with ER/LA opioids might be particularly high during the first 2 weeks of treatment (KQ3). The contextual evidence review found that patients who do not have pain relief with opioids at 1 month are unlikely to experience pain relief with opioids at 6 months. Although evidence is insufficient to determine at what point within the first 3 months of opioid therapy the risks for opioid use disorder increase, reassessment of pain and function within 1 month of initiating opioids provides an opportunity to minimize risks of long-term opioid use by discontinuing opioids among patients not receiving a clear benefit from these medications. Experts noted that risks for opioid overdose are greatest during the first 3–7 days after opioid initiation or increase in dosage, particularly when methadone or transdermal fentanyl are prescribed; that follow-up within 3 days is appropriate when initiating or increasing the dosage of methadone; and that follow-up within 1 week might be appropriate when initiating or increasing the dosage of other ER/LA opioids.

Clinicians should evaluate patients to assess benefits and harms of opioids within 1 to 4 weeks of starting long-term opioid therapy or of dose escalation. Clinicians should consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased or when total daily opioid dosage is ≥50 MME/day. Shorter follow-up intervals (within 3 days) should be strongly considered when starting or increasing the dosage of methadone. At follow up, clinicians should assess benefits in function, pain control, and quality of life using tools such as the three-item "Pain average, interference with Enjoyment of life, and interference with General activity" (PEG) Assessment Scale (*186*) and/or asking patients about progress toward functional goals that have meaning for them (see Recommendation 2). Clinicians should also ask patients about common adverse effects such as constipation and drowsiness (see Recommendation 3), as well as asking about and assessing for effects that might be early warning signs for more serious problems such as overdose (e.g., sedation or slurred speech) or opioid use disorder (e.g., craving, wanting to take opioids in greater quantities or more frequently than prescribed, or difficulty controlling use). Clinicians should ask patients about their preferences for continuing opioids, given their effects on pain and function relative to any adverse effects experienced.

Because of potential changes in the balance of benefits and risks of opioid therapy over time, clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, at least every 3 months. At reassessment, clinicians should determine whether opioids continue to meet treatment goals, including sustained improvement in pain and function, whether the patient has experienced common or serious adverse events or early warning signs of serious adverse events, signs of opioid use disorder (e.g., difficulty controlling use, work or family problems related to opioid use), whether benefits of opioids continue to outweigh risks, and whether opioid dosage can be reduced or opioids can be discontinued. Ideally, these reassessments would take place in person and be conducted by the prescribing clinician. In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other issues make follow-up visits challenging), follow-up assessments that allow the clinician to communicate with and observe the patient through video and audio could be conducted, with in-person visits occurring at least once per year. Clinicians should re-evaluate patients who are exposed to greater risk of opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months. If clinically meaningful improvements in pain and function are not sustained, if patients are taking high-risk regimens (e.g., dosages ≥50 MME/day or opioids combined with benzodiazepines) without evidence of benefit, if patients believe benefits no longer outweigh risks or if they request dosage reduction or discontinuation, or if patients experience overdose or other serious adverse events (e.g., an event leading to hospitalization or disability) or warning signs of serious adverse events, clinicians should work with patients to reduce opioid dosage or to discontinue opioids when possible. Clinicians should maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 1) and consider consulting a pain specialist as needed to assist with pain management.

### Considerations for Tapering Opioids

Although the clinical evidence review did not find high-quality studies comparing the effectiveness of different tapering protocols for use when opioid dosage is reduced or opioids are discontinued (KQ3), tapers reducing weekly dosage by 10%–50% of the original dosage have been recommended by other clinical guidelines (*199*), and a rapid taper over 2–3 weeks has been recommended in the case of a severe adverse event such as overdose (*30*). Experts noted that tapers slower than 10% per week (e.g., 10% per month) also might be appropriate and better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations (e.g., for years). Opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor.

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agreed that tapering plans may be individualized based on patient goals and concerns. Experts noted that at times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed once patients reach low dosages. Tapers may be considered successful as long as the patient is making progress. Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day. More rapid tapers might be needed for patient safety under certain circumstances (e.g., for patients who have experienced overdose on their current dosage). Ultrarapid detoxification under anesthesia is associated with substantial risks, including death, and should not be used (*200*). Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal. Patients who are not taking opioids (including patients who are diverting all opioids they obtain) do not require tapers. Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose. Primary care clinicians should collaborate with mental health providers and with other specialists as needed to optimize nonopioid pain management (see Recommendation 1), as well as psychosocial support for anxiety related to the taper. More detailed guidance on tapering, including management of withdrawal symptoms has been published previously (*30*,*201*). If a patient exhibits signs of opioid use disorder, clinicians should offer or arrange for treatment of opioid use disorder (see Recommendation 12) and consider offering naloxone for overdose prevention (see Recommendation 8).

## Assessing Risk and Addressing Harms of Opioid Use

8. **Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).**

The clinical evidence review found insufficient evidence to determine how harms of opioids differ depending on patient demographics or patient comorbidities (KQ2). However, based on the contextual evidence review and expert opinion, certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk. Clinicians should assess these risk factors periodically, with frequency varying by risk factor and patient characteristics. For example, factors that vary more frequently over time, such as alcohol use, require more frequent follow up. In addition, clinicians should consider offering naloxone, re-evaluating patients more frequently (see Recommendation 7), and referring to pain and/or behavioral health specialists when factors that increase risk for harm, such as history of overdose, history of substance use disorder, higher dosages of opioids (≥50 MME/day), and concurrent use of benzodiazepines with opioids, are present.

### Patients with Sleep-Disordered Breathing, Including Sleep Apnea

Risk factors for sleep-disordered breathing include congestive heart failure, and obesity. Experts noted that careful monitoring and cautious dose titration should be used if opioids are prescribed for patients with mild sleep-disordered breathing. Clinicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing whenever possible to minimize risks for opioid overdose (contextual evidence review).

### Pregnant Women

Opioids used in pregnancy might be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with stillbirth, poor fetal growth, pre-term delivery, and birth defects (contextual evidence review). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome. Clinicians and patients together should carefully weigh risks and benefits when making decisions

about whether to initiate opioid therapy for chronic pain during pregnancy. In addition, before initiating opioid therapy for chronic pain for reproductive-age women, clinicians should discuss family planning and how long-term opioid use might affect any future pregnancy. For pregnant women already receiving opioids, clinicians should access appropriate expertise if considering tapering opioids because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal (see Recommendation 7). For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes and should be offered (*202*) (see Recommendation 12). Clinicians caring for pregnant women receiving opioids for pain or receiving buprenorphine or methadone for opioid use disorder should arrange for delivery at a facility prepared to monitor, evaluate for, and treat neonatal opioid withdrawal syndrome. In instances when travel to such a facility would present an undue burden on the pregnant woman, it is appropriate to deliver locally, monitor and evaluate the newborn for neonatal opioid withdrawal syndrome, and transfer the newborn for additional treatment if needed. Neonatal toxicity and death have been reported in breast-feeding infants whose mothers are taking codeine (contextual evidence review); previous guidelines have recommended that codeine be avoided whenever possible among mothers who are breast feeding and, if used, should be limited to the lowest possible dose and to a 4-day supply (*203*).

### Patients with Renal or Hepatic Insufficiency

Clinicians should use additional caution and increased monitoring (see Recommendation 7) to minimize risks of opioids prescribed for patients with renal or hepatic insufficiency, given their decreased ability to process and excrete drugs, susceptibility to accumulation of opioids, and reduced therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (contextual evidence review; see Recommendations 4, 5, and 7).

### Patients Aged ≥65 Years

Inadequate pain treatment among persons aged ≥65 years has been documented (*204*). Pain management for older patients can be challenging given increased risks of both nonopioid pharmacologic therapies (see Recommendation 1) and opioid therapy in this population. Given reduced renal function and medication clearance even in the absence of renal disease, patients aged ≥65 years might have increased susceptibility to accumulation of opioids and a smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (contextual evidence review). Some older adults suffer from cognitive impairment, which can increase risk for medication errors and make opioid-related confusion more dangerous. In addition, older adults are more likely than younger adults to experience co-morbid medical conditions and more likely to receive multiple medications, some of which might interact with opioids (such as benzodiazepines). Clinicians should use additional caution and increased monitoring (see Recommendations 4, 5, and 7) to minimize risks of opioids prescribed for patients aged ≥65 years. Experts suggested that clinicians educate older adults receiving opioids to avoid risky medication-related behaviors such as obtaining controlled medications from multiple prescribers and saving unused medications. Clinicians should also implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient monitoring for cognitive impairment.

### Patients with Mental Health Conditions

Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, using validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (*205*), might help clinicians improve overall pain treatment outcomes. Experts noted that clinicians should use additional caution and increased monitoring (see Recommendation 7) to lessen the increased risk for opioid use disorder among patients with mental health conditions (including depression, anxiety disorders, and PTSD), as well as increased risk for drug overdose among patients with depression. Previous guidelines have noted that opioid therapy should not be initiated during acute psychiatric instability or uncontrolled suicide risk, and that clinicians should consider behavioral health specialist consultation for any patient with a history of suicide attempt or psychiatric disorder (*31*). In addition, patients with anxiety disorders and other mental health conditions are more likely to receive benzodiazepines, which can exacerbate opioid-induced respiratory depression and increase risk for overdose (see Recommendation 11). Clinicians should ensure that treatment for depression and other mental health conditions is optimized, consulting with behavioral health specialists when needed. Treatment for depression can improve pain symptoms as well as depression and might decrease overdose risk (contextual evidence review). For treatment of chronic pain in patients with depression, clinicians should strongly consider using tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects if these medications are not otherwise contraindicated (see Recommendation 1).

### Patients with Substance Use Disorder

Illicit drugs and alcohol are listed as contributory factors on a substantial proportion of death certificates for opioid-related overdose deaths (contextual evidence review). Previous guidelines have recommended screening or risk assessment tools to identify patients at higher risk for misuse or abuse of opioids. However, the clinical evidence review found that currently available risk-stratification tools (e.g., Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain Version 1, SOAPP-R, and Brief Risk Interview) show insufficient accuracy for classification of patients as at low or high risk for abuse or misuse (KQ4). Clinicians should always exercise caution when considering or prescribing opioids for any patient with chronic pain outside of active cancer, palliative, and end-of-life care and should not overestimate the ability of these tools to rule out risks from long-term opioid therapy.

Clinicians should ask patients about their drug and alcohol use. Single screening questions can be used (*206*). For example, the question "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" (with an answer of one or more considered positive) was found in a primary care setting to be 100% sensitive and 73.5% specific for the detection of a drug use disorder compared with a standardized diagnostic interview (*207*). Validated screening tools such as the Drug Abuse Screening Test (DAST) (*208*) and the Alcohol Use Disorders Identification Test (AUDIT) (*209*) can also be used. Clinicians should use PDMP data (see Recommendation 9) and drug testing (see Recommendation 10) as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose. Clinicians should also provide specific counseling on increased risks for overdose when opioids are combined with other drugs or alcohol (see Recommendation 3) and ensure that patients receive effective treatment for substance use disorders when needed (see Recommendation 12).

The clinical evidence review found insufficient evidence to determine how harms of opioids differ depending on past or current substance use disorder (KQ2), although a history of substance use disorder was associated with misuse. Similarly, based on contextual evidence, patients with drug or alcohol use disorders are likely to experience greater risks for opioid use disorder and overdose than persons without these conditions. If clinicians consider opioid therapy for chronic pain outside of active cancer, palliative, and end-of-life care for patients with drug or alcohol use disorders, they should discuss increased risks for opioid use disorder and overdose with patients, carefully consider whether benefits of opioids outweigh increased risks, and incorporate strategies to mitigate risk into the management plan, such as considering offering naloxone (see Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present) and increasing frequency of monitoring (see Recommendation 7) when opioids are prescribed. Because pain management in patients with substance use disorder can be complex, clinicians should consider consulting substance use disorder specialists and pain specialists regarding pain management for persons with active or recent past history of substance abuse. Experts also noted that clinicians should communicate with patients' substance use disorder treatment providers if opioids are prescribed.

### Patients with Prior Nonfatal Overdose

Although studies were not identified that directly addressed the risk for overdose among patients with prior nonfatal overdose who are prescribed opioids, based on clinical experience, experts thought that prior nonfatal overdose would substantially increase risk for future nonfatal or fatal opioid overdose. If patients experience nonfatal opioid overdose, clinicians should work with them to reduce opioid dosage and to discontinue opioids when possible (see Recommendation 7). If clinicians continue opioid therapy for chronic pain outside of active cancer, palliative, and end-of-life care in patients with prior opioid overdose, they should discuss increased risks for overdose with patients, carefully consider whether benefits of opioids outweigh substantial risks, and incorporate strategies to mitigate risk into the management plan, such as considering offering naloxone (see Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present) and increasing frequency of monitoring (see Recommendation 7) when opioids are prescribed.

### Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present

Naloxone is an opioid antagonist that can reverse severe respiratory depression; its administration by lay persons, such as friends and family of persons who experience opioid overdose, can save lives. Naloxone precipitates acute withdrawal among patients physically dependent on opioids. Serious adverse effects, such as pulmonary edema, cardiovascular instability, and seizures, have been reported but are rare at doses consistent with labeled use for opioid overdose (*210*). The contextual evidence review did not find any studies on effectiveness of prescribing naloxone for overdose prevention among patients prescribed opioids for chronic pain. However, there is evidence for effectiveness of naloxone provision in preventing opioid-related overdose death at the community level through community-based distribution (e.g., through overdose education and naloxone distribution programs in community service agencies) to persons at risk for overdose

(mostly due to illicit opiate use), and it is plausible that effectiveness would be observed when naloxone is provided in the clinical setting as well. Experts agreed that it is preferable not to initiate opioid treatment when factors that increase risk for opioid-related harms are present. Opinions diverged about the likelihood of naloxone being useful to patients and the circumstances under which it should be offered. However, most experts agreed that clinicians should consider offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids (see Recommendation 11), patients at risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison), and patients taking higher dosages of opioids (≥50 MME/day). Practices should provide education on overdose prevention and naloxone use to patients receiving naloxone prescriptions and to members of their households. Experts noted that naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training and by collaborative practice models with pharmacists. Resources for prescribing naloxone in primary care settings can be found through Prescribe to Prevent at http://prescribetoprevent.org.

9. **Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).**

PDMPs are state-based databases that collect information on controlled prescription drugs dispensed by pharmacies in most states and, in select states, by dispensing physicians as well. In addition, some clinicians employed by the federal government, including some clinicians in the Indian Health Care Delivery System, are not licensed in the states where they practice, and do not have access to PDMP data. Certain states require clinicians to review PDMP data prior to writing each opioid prescription (see state-level PDMP-related policies on the National Alliance for Model State Drug Laws website at http://www.namsdl.org/prescription-monitoring-programs.cfm). The clinical evidence review did not find studies evaluating the effectiveness of PDMPs on outcomes related to overdose, addiction, abuse, or misuse (KQ4). However, even though evidence is limited on the effectiveness of PDMP implementation at the state level on prescribing and mortality outcomes (*28*), the contextual evidence review found that most fatal overdoses were associated with patients receiving opioids from multiple prescribers and/or with patients receiving high total daily opioid dosages; information on both of these risk factors for overdose are available to prescribers in the PDMP. PDMP data also can be helpful when patient medication history is not otherwise available (e.g., for patients from other locales) and when patients transition care to a new clinician. The contextual evidence review also found that PDMP information could be used in a way that is harmful to patients. For example, it has been used to dismiss patients from clinician practices (*211*), which might adversely affect patient safety.

The contextual review found variation in state policies that affect timeliness of PDMP data (and therefore benefits of reviewing PDMP data) as well as time and workload for clinicians in accessing PDMP data. In states that permit delegating access to other members of the health care team, workload for prescribers can be reduced. These differences might result in a different balance of benefits to clinician workload in different states. Experts agreed that PDMPs are useful tools that should be consulted when starting a patient on opioid therapy and periodically during long-term opioid therapy. However, experts disagreed on how frequently clinicians should check the PDMP during long-term opioid therapy, given PDMP access issues and the lag time in reporting in some states. Most experts agreed that PDMP data should be reviewed every 3 months or more frequently during long-term opioid therapy. A minority of experts noted that, given the current burden of accessing PDMP data in some states and the lack of evidence surrounding the most effective interval for PDMP review to improve patient outcomes, annual review of PDMP data during long-term opioid therapy would be reasonable when factors that increase risk for opioid-related harms are not present.

Clinicians should review PDMP data for opioids and other controlled medications patients might have received from additional prescribers to determine whether a patient is receiving high total opioid dosages or dangerous combinations (e.g., opioids combined with benzodiazepines) that put him or her at high risk for overdose. Ideally, PDMP data should be reviewed before every opioid prescription. This is recommended in all states with well-functioning PDMPs and where PDMP access policies make this practicable (e.g., clinician and delegate access permitted), but it is not currently possible in states without functional PDMPs or in those that do not permit certain prescribers to access them. As vendors and practices facilitate integration of PDMP information into regular clinical workflow (e.g., data made available in electronic health records), clinicians' ease of access in reviewing PDMP data is expected to improve.

In addition, improved timeliness of PDMP data will improve their value in identifying patient risks.

If patients are found to have high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions written by different clinicians, several actions can be taken to augment clinicians' abilities to improve patient safety:

- Clinicians should discuss information from the PDMP with their patient and confirm that the patient is aware of the additional prescriptions. Occasionally, PDMP information can be incorrect (e.g., if the wrong name or birthdate has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).
- Clinicians should discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving opioids from more than one prescriber or receiving medications that increase risk when combined with opioids (e.g., benzodiazepines) and consider offering naloxone (see Recommendation 8).
- Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care (see Recommendation 11).
- Clinicians should calculate the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk (see Recommendation 5). If patients are found to be receiving high total daily dosages of opioids, clinicians should discuss their safety concerns with the patient, consider tapering to a safer dosage (see Recommendations 5 and 7), and consider offering naloxone (see Recommendation 8).
- Clinicians should discuss safety concerns with other clinicians who are prescribing controlled substances for their patient. Ideally clinicians should first discuss concerns with their patient and inform him or her that they plan to coordinate care with the patient's other prescribers to improve the patient's safety.
- Clinicians should consider the possibility of a substance use disorder and discuss concerns with their patient (see Recommendation 12).
- If clinicians suspect their patient might be sharing or selling opioids and not taking them, clinicians should consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal (see Recommendations 7 and 10). A negative drug test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result (see Recommendation 10).

Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of opioids and overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendation 1], naloxone [see Recommendation 8], and effective treatment for substance use disorder [see Recommendation 12]).

**10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).**

Concurrent use of opioid pain medications with other opioid pain medications, benzodiazepines, or heroin can increase patients' risk for overdose. Urine drug tests can provide information about drug use that is not reported by the patient. In addition, urine drug tests can assist clinicians in identifying when patients are not taking opioids prescribed for them, which might in some cases indicate diversion or other clinically important issues such as difficulties with adverse effects. Urine drug tests do not provide accurate information about how much or what dose of opioids or other drugs a patient took. The clinical evidence review did not find studies evaluating the effectiveness of urine drug screening for risk mitigation during opioid prescribing for pain (KQ4). The contextual evidence review found that urine drug testing can provide useful information about patients assumed not to be using unreported drugs. Urine drug testing results can be subject to misinterpretation and might sometimes be associated with practices that might harm patients (e.g., stigmatization, inappropriate termination from care). Routine use of urine drug tests with standardized policies at the practice or clinic level might destigmatize their use. Although random drug testing also might destigmatize urine drug testing, experts thought that truly random testing was not feasible in clinical practice. Some clinics obtain a urine specimen at every visit, but only send it for testing on a random schedule. Experts noted that in addition to direct costs of urine drug testing, which often are not covered fully by insurance and can be a burden for patients, clinician time is needed to interpret, confirm, and communicate results.

Experts agreed that prior to starting opioids for chronic pain and periodically during opioid therapy, clinicians should

use urine drug testing to assess for prescribed opioids as well as other controlled substances and illicit drugs that increase risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, and heroin. There was some difference of opinion among experts as to whether this recommendation should apply to all patients, or whether this recommendation should entail individual decision making with different choices for different patients based on values, preferences, and clinical situations. While experts agreed that clinicians should use urine drug testing before initiating opioid therapy for chronic pain, they disagreed on how frequently urine drug testing should be conducted during long-term opioid therapy. Most experts agreed that urine drug testing at least annually for all patients was reasonable. Some experts noted that this interval might be too long in some cases and too short in others, and that the follow-up interval should be left to the discretion of the clinician. Previous guidelines have recommended more frequent urine drug testing in patients thought to be at higher risk for substance use disorder (*30*). However, experts thought that predicting risk prior to urine drug testing is challenging and that currently available tools do not allow clinicians to reliably identify patients who are at low risk for substance use disorder.

In most situations, initial urine drug testing can be performed with a relatively inexpensive immunoassay panel for commonly prescribed opioids and illicit drugs. Patients prescribed less commonly used opioids might require specific testing for those agents. The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard immunoassays or on the presence of unexpected urine drug test results. Clinicians should be familiar with the drugs included in urine drug testing panels used in their practice and should understand how to interpret results for these drugs. For example, a positive "opiates" immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but this immunoassay does not detect synthetic opioids (e.g., fentanyl or methadone) and might not detect semisynthetic opioids (e.g., oxycodone). However, many laboratories use an oxycodone immunoassay that detects oxycodone and oxymorphone. In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid for which the test was positive. For example, hydromorphone is a metabolite of hydrocodone, and oxymorphone is a metabolite of oxycodone. Detailed guidance on interpretation of urine drug test results, including which tests to order and expected results, drug detection time in urine, drug metabolism, and other considerations has been published previously (*30*). Clinicians should not test for substances for which results would not affect patient management or for which implications for patient management are unclear. For example, experts noted that there might be uncertainty about the clinical implications of a positive urine drug test for tetrahyrdocannabinol (THC). In addition, restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management can reduce costs of urine drug testing, given the substantial costs associated with confirmatory testing methods. Before ordering urine drug testing, clinicians should have a plan for responding to unexpected results. Clinicians should explain to patients that urine drug testing is intended to improve their safety and should also explain expected results (e.g., presence of prescribed medication and absence of drugs, including illicit drugs, not reported by the patient). Clinicians should ask patients about use of prescribed and other drugs and ask whether there might be unexpected results. This will provide an opportunity for patients to provide information about changes in their use of prescribed opioids or other drugs. Clinicians should discuss unexpected results with the local laboratory or toxicologist and with the patient. Discussion with patients prior to specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and obviate the need for expensive confirmatory testing on that visit. For example, a patient might explain that the test is negative for prescribed opioids because she felt opioids were no longer helping and discontinued them. If unexpected results are not explained, a confirmatory test using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography/mass spectrometry) might be warranted to clarify the situation.

Clinicians should use unexpected results to improve patient safety (e.g., change in pain management strategy [see Recommendation 1], tapering or discontinuation of opioids [see Recommendation 7], more frequent re-evaluation [see Recommendation 7], offering naloxone [see Recommendation 8], or referral for treatment for substance use disorder [see Recommendation 12], all as appropriate). If tests for prescribed opioids are repeatedly negative, confirming that the patient is not taking the prescribed opioid, clinicians can discontinue the prescription without a taper. Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.

**11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently**

**whenever possible (recommendation category: A, evidence type: 3).**

Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to put patients at greater risk for potentially fatal overdose. The clinical evidence review did not address risks of benzodiazepine co-prescription among patients prescribed opioids. However, the contextual evidence review found evidence in epidemiologic series of concurrent benzodiazepine use in large proportions of opioid-related overdose deaths, and a case-cohort study found concurrent benzodiazepine prescription with opioid prescription to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone (*212*). Experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. In addition, given that other central nervous system depressants (e.g., muscle relaxants, hypnotics) can potentiate central nervous system depression associated with opioids, clinicians should consider whether benefits outweigh risks of concurrent use of these drugs. Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9) and should consider involving pharmacists and pain specialists as part of the management team when opioids are co-prescribed with other central nervous system depressants. Because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first (see Recommendation 7). Clinicians should taper benzodiazepines gradually if discontinued because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death (contextual evidence review). A commonly used tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1–2 weeks (*213*,*214*). CBT increases tapering success rates and might be particularly helpful for patients struggling with a benzodiazepine taper (*213*). If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., CBT) and/or specific anti-depressants or other nonbenzodiazepine medications approved for anxiety should be offered. Experts emphasized that clinicians should communicate with mental health professionals managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.

**12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).**

Opioid use disorder (previously classified as opioid abuse or opioid dependence) is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) as a problematic pattern of opioid use leading to clinically significant impairment or distress, manifested by at least two defined criteria occurring within a year (http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf) (*20*).

The clinical evidence review found prevalence of opioid dependence (using DSM-IV diagnosis criteria) in primary care settings among patients with chronic pain on opioid therapy to be 3%–26% (KQ2). As found in the contextual evidence review and supported by moderate quality evidence, opioid agonist or partial agonist treatment with methadone maintenance therapy or buprenorphine has been shown to be more effective in preventing relapse among patients with opioid use disorder (*151*–*153*). Some studies suggest that using behavioral therapies in combination with these treatments can reduce opioid misuse and increase retention during maintenance therapy and improve compliance after detoxification (*154*,*155*); behavioral therapies are also recommended by clinical practice guidelines (*215*). The cited studies primarily evaluated patients with a history of illicit opioid use, rather than prescription opioid use for chronic pain. Recent studies among patients with prescription opioid dependence (based on DSM-IV criteria) have found maintenance therapy with buprenorphine and buprenorphine-naloxone effective in preventing relapse (*216*,*217*). Treatment need in a community is often not met by capacity to provide buprenorphine or methadone maintenance therapy (*218*), and patient cost can be a barrier to buprenorphine treatment because insurance coverage of buprenorphine for opioid use disorder is often limited (*219*). Oral or long-acting injectable formulations of naltrexone can also be used as medication-assisted treatment for opioid use disorder in nonpregnant adults, particularly for highly motivated persons (*220*,*221*). Experts agreed that clinicians prescribing opioids should identify treatment resources for opioid use disorder in the community and should work together to ensure sufficient treatment capacity for opioid use disorder at the practice level.

If clinicians suspect opioid use disorder based on patient concerns or behaviors or on findings in prescription drug monitoring program data (see Recommendation 9) or from urine drug testing (see Recommendation 10), they should discuss their concern with their patient and provide an opportunity for the patient to disclose related concerns or problems. Clinicians should assess for the presence of opioid use disorder using DSM-5 criteria (*20*). Alternatively, clinicians can arrange for a substance use disorder treatment specialist to assess for the presence of opioid use disorder. For patients meeting criteria for opioid use disorder, clinicians should offer or arrange for patients to receive evidence-based treatment, usually medication-assisted treatment with buprenorphine or methadone maintenance therapy in combination with behavioral therapies. Oral or long-acting injectable naltrexone, a long-acting opioid antagonist, can also be used in non-pregnant adults. Naltrexone blocks the effects of opioids if they are used but requires adherence to daily oral therapy or monthly injections. For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine (without naloxone) or methadone has been associated with improved maternal outcomes and should be offered (see Recommendation 8). Clinicians should also consider offering naloxone for overdose prevention to patients with opioid use disorder (see Recommendation 8). For patients with problematic opioid use that does not meet criteria for opioid use disorder, experts noted that clinicians can offer to taper and discontinue opioids (see Recommendation 7). For patients who choose to but are unable to taper, clinicians may reassess for opioid use disorder and offer opioid agonist therapy if criteria are met.

Physicians not already certified to provide buprenorphine in an office-based setting can undergo training to receive a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) that allows them to prescribe buprenorphine to treat patients with opioid use disorder. Physicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder should strongly consider obtaining this waiver. Information about qualifications and the process to obtain a waiver are available from SAMHSA (*222*). Clinicians do not need a waiver to offer naltrexone for opioid use disorder as part of their practice.

Additional guidance has been published previously (*215*) on induction, use, and monitoring of buprenorphine treatment (see Part 5) and naltrexone treatment (see Part 6) for opioid use disorder and on goals, components of, and types of effective psychosocial treatment that are recommended in conjunction with pharmacological treatment of opioid use disorder (see Part 7). Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist, such as an office-based buprenorphine or naltrexone treatment provider, or from an opioid treatment program certified by SAMHSA to provide supervised medication-assisted treatment for patients with opioid use disorder. Clinicians should assist patients in finding qualified treatment providers and should arrange for patients to follow up with these providers, as well as arranging for ongoing coordination of care. Clinicians should not dismiss patients from their practice because of a substance use disorder because this can adversely affect patient safety and could represent patient abandonment. Identification of substance use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and it is important for the clinician to collaborate with the patient regarding their safety to increase the likelihood of successful treatment. In addition, although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. Clinicians should continue to use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate (see Recommendation 1) and consider consulting a pain specialist as needed to provide optimal pain management.

Resources to help with arranging for treatment include SAMHSA's buprenorphine physician locator (http://buprenorphine.samhsa.gov/bwns_locator); SAMHSA's Opioid Treatment Program Directory (http://dpt2.samhsa.gov/treatment/directory.aspx); SAMHSA's Provider Clinical Support System for Opioid Therapies (http://pcss-o.org), which offers extensive experience in the treatment of substance use disorders and specifically of opioid use disorder, as well as expertise on the interface of pain and opioid misuse; and SAMHSA's Provider's Clinical Support System for Medication-Assisted Treatment (http://pcssmat.org), which offers expert physician mentors to answer questions about assessment for and treatment of substance use disorders.

## Conclusions and Future Directions

Clinical guidelines represent one strategy for improving prescribing practices and health outcomes. Efforts are required to disseminate the guideline and achieve widespread adoption and implementation of the recommendations in clinical settings. CDC will translate this guideline into user-friendly materials for distribution and use by health systems, medical professional societies, insurers, public health departments, health information technology developers, and clinicians and engage in dissemination efforts. CDC has provided a

checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025), additional resources such as fact sheets (http://www.cdc.gov/drugoverdose/prescribing/resources.html), and will provide a mobile application to guide clinicians in implementing the recommendations. CDC will also work with partners to support clinician education on pain management options, opioid therapy, and risk mitigation strategies (e.g., urine drug testing). Activities such as development of clinical decision support in electronic health records to assist clinicians' treatment decisions at the point of care; identification of mechanisms that insurers and pharmacy benefit plan managers can use to promote safer prescribing within plans; and development of clinical quality improvement measures and initiatives to improve prescribing and patient care within health systems have promise for increasing guideline adoption and improving practice. In addition, policy initiatives that address barriers to implementation of the guidelines, such as increasing accessibility of PDMP data within and across states, e-prescribing, and availability of clinicians who can offer medication-assisted treatment for opioid use disorder, are strategies to consider to enhance implementation of the recommended practices. CDC will work with federal partners and payers to evaluate strategies such as payment reform and health care delivery models that could improve patient health and safety. For example, strategies might include strengthened coverage for nonpharmacologic treatments, appropriate urine drug testing, and medication-assisted treatment; reimbursable time for patient counseling; and payment models that improve access to interdisciplinary, coordinated care.

As highlighted in the forthcoming report on the National Pain Strategy, an overarching federal effort that outlines a comprehensive population-level health strategy for addressing pain as a public health problem, clinical guidelines complement other strategies aimed at preventing illnesses and injuries that lead to pain. A draft of the National Pain Strategy has been published previously (*180*). These strategies include strengthening the evidence base for pain prevention and treatment strategies, reducing disparities in pain treatment, improving service delivery and reimbursement, supporting professional education and training, and providing public education. It is important that overall improvements be made in developing the workforce to address pain management in general, in addition to opioid prescribing specifically. This guideline also complements other federal efforts focused on addressing the opioid overdose epidemic including prescriber training and education, improving access to treatment for opioid use disorder, safe storage and disposal programs, utilization management mechanisms, naloxone distribution programs, law enforcement and supply reduction efforts, prescription drug monitoring program improvements, and support for community coalitions and state prevention programs.

This guideline provides recommendations that are based on the best available evidence that was interpreted and informed by expert opinion. The clinical scientific evidence informing the recommendations is low in quality. To inform future guideline development, more research is necessary to fill in critical evidence gaps. The evidence reviews forming the basis of this guideline clearly illustrate that there is much yet to be learned about the effectiveness, safety, and economic efficiency of long-term opioid therapy. As highlighted by an expert panel in a recent workshop sponsored by the National Institutes of Health on the role of opioid pain medications in the treatment of chronic pain, "evidence is insufficient for every clinical decision that a provider needs to make about the use of opioids for chronic pain" (*223*). The National Institutes of Health panel recommended that research is needed to improve our understanding of which types of pain, specific diseases, and patients are most likely to be associated with benefit and harm from opioid pain medications; evaluate multidisciplinary pain interventions; estimate cost-benefit; develop and validate tools for identification of patient risk and outcomes; assess the effectiveness and harms of opioid pain medications with alternative study designs; and investigate risk identification and mitigation strategies and their effects on patient and public health outcomes. It is also important to obtain data to inform the cost feasibility and cost-effectiveness of recommended actions, such as use of nonpharmacologic therapy and urine drug testing. Research that contributes to safer and more effective pain treatment can be implemented across public health entities and federal agencies (*4*). Additional research can inform the development of future guidelines for special populations that could not be adequately addressed in this guideline, such as children and adolescents, where evidence and guidance is needed but currently lacking. CDC is committed to working with partners to identify the highest priority research areas to build the evidence base. Yet, given that chronic pain is recognized as a significant public health problem, the risks associated with long-term opioid therapy, the availability of effective nonpharmacological and nonopioid pharmacologic treatment options for pain, and the potential for improvement in the quality of health care with the implementation of recommended practices, a guideline for prescribing is warranted with the evidence that is currently available. The balance between the benefits and the risks of long-term opioid therapy for chronic pain based on both clinical and contextual evidence is strong enough to support the issuance of category A recommendations in most cases.

CDC will revisit this guideline as new evidence becomes available to determine when evidence gaps have been sufficiently closed to warrant an update of the guideline. Until this research is conducted, clinical practice guidelines will have to be based on the best available evidence and expert opinion. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC is committed to evaluating the guideline to identify the impact of the recommendations on clinician and patient outcomes, both intended and unintended, and revising the recommendations in future updates when warranted.

## Acknowledgments

Members of the Core Expert Group; the Core Expert Group facilitator: Don Teater, MD; members of the Stakeholder Review Group; peer reviewers; the Opioid Guideline Workgroup, consultants, and the NCIPC Board of Scientific Counselors; federal partners: Richard Kronick, PhD, Deborah G. Perfetto, PharmD, Agency for Healthcare Research and Quality; Jeffrey A. Kelman, MD, Diane L. McNally, Centers for Medicare & Medicaid Services; Jonathan Woodson, MD, Dave Smith, MD, Jack Smith, MD, Christopher Spevak, MD, Department of Defense; Stephen M. Ostroff, MD, Christopher M. Jones, PharmD, Food and Drug Administration; Jim Macrae, MA, MPP, Alexander F. Ross, ScD, Health Resources and Services Administration; Nora Volkow, MD, David Thomas, PhD, National Institute of Drug Abuse; John Howard, MD, Douglas Trout, MD, National Institute for Occupational Safety and Health; Karen B. DeSalvo, MD, Jennifer Frazier, MPH, Office of the National Coordinator, Michael Botticelli, MEd, Cecelia McNamara Spitznas, PhD, Office of National Drug Control Policy; Kana Enomoto, MA, Jinhee Lee, PharmD, Substance Abuse and Mental Health Services Administration; Robert McDonald, MBA, Jack M. Rosenberg, MD, Veterans Administration; members of the public who provided comment during the webinar; Douglas McDonald, PhD, Brandy Wyant, MPH, Kenneth Carlson, Amy Berninger, MPH, Abt Associates; Thomas Frieden, MD, Anne Schuchat, MD, Ileana Arias, PhD, CDC Office of the Director, Debra Houry, MD, National Center for Injury Prevention and Control, Amy Peeples, MPA, National Center for Injury Prevention and Control, Arlene Greenspan, DrPH, National Center for Injury Prevention and Control, Grant Baldwin, PhD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Rita Noonan, PhD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Julie Gilchrist, MD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Terry Davis, EdD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Wes Sargent, EdD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Brian Manns, PharmD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Lisa Garbarino, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Donovan Newton, MPA, Division of Analysis, Research and Practice Integration, National Center for Injury Prevention and Control, Joann Kang, JD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Noah Aleshire, JD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Jennifer VanderVeur, JD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, LeShaundra Scott, MPH, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Sarah Lewis, MPH, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Helen Kingery, MPH, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Kristen Sanderson, MPH, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Kate Fox, MPP, National Center for Injury Prevention and Control, Leslie Dorigo, MA, National Center for Injury Prevention and Control, Erin Connelly, MPA, National Center for Injury Prevention and Control, Sara Patterson, MA, National Center for Injury Prevention and Control, Mark Biagioni, MPA, National Center for Injury Prevention and Control, and Leonard J. Paulozzi, MD, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

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**TABLE 1. Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain**

| Outcome | Studies | Limitations | Inconsistency | Imprecision | Type of evidence | Other factors | Estimates of effect/findings |
|---|---|---|---|---|---|---|---|
| **Effectiveness and comparative effectiveness (KQ1)** | | | | | | | |
| **Effectiveness of long-term opioid therapy versus placebo or no opioid therapy for long-term (≥1 year) outcomes** | | | | | | | |
| Pain, function, and quality of life | None | —[†] | — | — | Insufficient | — | No evidence |
| **Harms and adverse events (KQ2)** | | | | | | | |
| **Risks of opioids versus placebo or no opioids on opioid abuse, addiction, and related outcomes; overdose; and other harms** | | | | | | | |
| Abuse or addiction | 1 cohort study (n = 568,640) | Serious limitations | Unknown (1 study) | No imprecision | 3 | None identified | One retrospective cohort study found long-term use of prescribed opioids associated with an increased risk of abuse or dependence diagnosis versus no opioid use (adjusted OR ranged from 14.9 to 122.5, depending on dose). |
| Abuse or addiction | 10 uncontrolled studies (n = 3,780) | Very serious limitations | Very serious inconsistency | No imprecision | 4 | None identified | In primary care settings, prevalence of opioid abuse ranged from 0.6% to 8% and prevalence of dependence from 3% to 26%. In pain clinic settings, prevalence of misuse ranged from 8% to 16% and addiction from 2% to 14%. Prevalence of aberrant drug-related behaviors ranged from 6% to 37%. |
| Overdose | 1 cohort study (n = 9,940) | Serious limitations | Unknown (1 study) | Serious imprecision | 3 | None identified | Current opioid use associated with increased risk of any overdose events (adjusted HR 5.2, 95% CI = 2.1–12) and serious overdose events (adjusted HR 8.4, 95% CI = 2.5–28) versus current nonuse. |
| Fractures | 1 cohort study (n = 2,341) and 1 case–control study (n = 21,739 case patients) | Serious limitations | No inconsistency | No imprecision | 3 | None identified | Opioid use associated with increased risk of fracture in 1 cohort study (adjusted HR 1.28, 95% CI = 0.99–1.64) and 1 case-control study (adjusted OR 1.27, 95% CI = 1.21–1.33). |
| Myocardial infarction | 1 cohort study (n = 426,124) and 1 case–control study (n = 11,693 case patients) | No limitations | No inconsistency | No imprecision | 3 | None identified | Current opioid use associated with increased risk of myocardial infarction versus nonuse (adjusted OR 1.28, 95% CI = 1.19–1.37 and incidence rate ratio 2.66, 95% CI = 2.30–3.08). |
| Endocrinologic harms | 1 cross-sectional study (n = 11,327) | Serious limitations | Unknown (1 study) | No imprecision | 3 | None identified | Long-term opioid use associated with increased risk for use of medications for erectile dysfunction or testosterone replacement versus nonuse (adjusted OR 1.5, 95% CI = 1.1–1.9). |
| **How do harms vary depending on the opioid dose used?** | | | | | | | |
| Abuse or addiction | 1 cohort study (n = 568,640) | Serious limitations | Unknown (1 study) | No imprecision | 3 | None identified | One retrospective cohort study found higher doses of long-term opioid therapy associated with increased risk of opioid abuse or dependence than lower doses. Compared to no opioid prescription, the adjusted odds ratios were 15 (95% CI = 10–21) for 1 to 36 MME/day, 29 (95 % CI = 20–41) for 36 to120 MME/day, and 122 (95 % CI = 73–205) for ≥120 MME/day. |
| Overdose | 1 cohort study (n = 9,940) and 1 case–control study (n = 593 case patients in primary analysis) | Serious limitations | No inconsistency | No imprecision | 3 | Magnitude of effect, dose response relationship | Versus 1 to <20 MME/day, one cohort study found an adjusted HR for an overdose event of 1.44 (95% CI = 0.57–3.62) for 20 to <50 MME/day that increased to 8.87 (95% CI = 3.99–19.72) at ≥100 MME/day; one case-control study found an adjusted OR for an opioid-related death of 1.32 (95% CI = 0.94–1.84) for 20 to 49 MME/day that increased to 2.88 (95% CI = 1.79–4.63) at ≥200 MME/day. |
| Fractures | 1 cohort study (n = 2,341) | Serious limitations | Unknown (1 study) | Serious imprecision | 3 | None identified | Risk of fracture increased from an adjusted HR of 1.20 (95% CI = 0.92–1.56) at 1 to <20 MME/day to 2.00 (95% CI = 1.24–3.24) at ≥50 MME/day; the trend was of borderline statistical significance. |

See table footnotes on page 47.

**TABLE 1. (*Continued*) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain**

| Outcome | Studies | Limitations | Inconsistency | Imprecision | Type of evidence | Other factors | Estimates of effect/findings |
|---|---|---|---|---|---|---|---|
| Myocardial infarction | 1 cohort study (n = 426,124) | Serious limitations | Unknown (1 study) | No imprecision | 3 | None identified | Relative to a cumulative dose of 0 to 1,350 MME during a 90-day period, the incidence rate ratio for myocardial infarction for 1350 to <2700 MME was 1.21 (95% CI = 1.02–1.45), for 2,700 to <8,100 MME was 1.42 (95% CI = 1.21–1.67), for 8,100 to <18,000 MME was 1.89 (95% CI = 1.54–2.33), and for ≥18,000 MME was 1.73 (95% CI = 1.32–2.26). |
| Motor vehicle crash injuries | 1 case–control study (n = 5,300 case patients) | No limitations | Unknown (1 study) | No imprecision | 3 | None identified | No association between opioid dose and risk of motor vehicle crash injuries even though opioid doses >20 MME/day were associated with increased odds of road trauma among drivers. |
| Endocrinologic harms | 1 cross-sectional study (n = 11,327) New for update: 1 additional cross-sectional study (n=1,585) | Serious limitations | Consistent | No imprecision | 3 | None identified | Relative to 0 to <20 MME/day, the adjusted OR for ≥120 MME/day for use of medications for erectile dysfunction or testosterone replacement was 1.6 (95% CI = 1.0–2.4).<br>One new cross-sectional study found higher-dose long-term opioid therapy associated with increased risk of androgen deficiency among men receiving immediate-release opioids (adjusted OR per 10 MME/day 1.16, 95% CI = 1.09–1.23), but the dose response was very weak among men receiving ER/LA opioids. |
| **Dosing strategies (KQ3)** | | | | | | | |
| **Comparative effectiveness of different methods for initiating opioid therapy and titrating doses** | | | | | | | |
| Pain | 3 randomized trials (n = 93) | Serious limitations | Serious inconsistency | Very serious imprecision | 4 | None identified | Trials on effects of titration with immediate-release versus ER/LA opioids reported inconsistent results and had additional differences between treatment arms in dosing protocols (titrated versus fixed dosing) and doses of opioids used. |
| Overdose | New for update: 1 cohort study (n = 840,606) | Serious limitations | Unknown (1 study) | No imprecision | 4 | None identified | One new cross-sectional study found initiation of therapy with an ER/LA opioid associated with increased risk of overdose versus initiation with an immediate-release opioid (adjusted HR 2.33, 95% CI = 1.26–4.32). |
| **Comparative effectiveness of different ER/LA opioids** | | | | | | | |
| Pain and function | 3 randomized trials (n = 1,850) | Serious limitations | No inconsistency | No imprecision | 3 | None identified | No differences |
| All-cause mortality | 1 cohort study (n = 108,492)<br>New for update: 1 cohort study (n = 38,756) | Serious limitations | Serious inconsistency | No imprecision | 4 | None identified | One cohort study found methadone to be associated with lower all-cause mortality risk than sustained-release morphine in a propensity-adjusted analysis (adjusted HR 0.56, 95% CI = 0.51–0.62) and one cohort study among Tennessee Medicaid patients found methadone to be associated with higher risk of all-cause mortality than sustained-release morphine (adjusted HR 1.46, 95% CI = 1.17–1.73). |
| Abuse and related outcomes | 1 cohort study (n = 5,684) | Serious limitations | Unknown (1 study) | Serious imprecision | 4 | None identified | One cohort study found some differences between ER/LA opioids in rates of adverse outcomes related to abuse, but outcomes were nonspecific for opioid-related adverse events, precluding reliable conclusions. |
| **ER/LA versus immediate-release opioids** | | | | | | | |
| Endocrinologic harms | New for update: 1 cross-sectional study (n = 1,585) | Serious limitations | Unknown (1 study) | No imprecision | 4 | None identified | One cross-sectional study found ER/LA opioids associated with increased risk of androgen deficiency versus immediate-release opioids (adjusted OR 3.39, 95% CI = 2.39–4.77). |

See table footnotes on page 47.

**TABLE 1. (*Continued*) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain**

| Outcome | Studies | Limitations | Inconsistency | Imprecision | Type of evidence | Other factors | Estimates of effect/findings |
|---|---|---|---|---|---|---|---|
| **Dose escalation versus dose maintenance or use of dose thresholds** | | | | | | | |
| Pain, function, or withdrawal due to opioid misuse | 1 randomized trial (n = 140) | Serious limitations | Unknown (1 study) | Very serious imprecision | 3 | None identified | No difference between more liberal dose escalation versus maintenance of current doses in pain, function, or risk of withdrawal due to opioid misuse, but there was limited separation in opioid doses between groups (52 versus 40 MME/day at the end of the trial). |
| **Immediate-release versus ER/LA opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled and continuous versus as-needed dosing of opioids; or opioid rotation versus maintenance of current therapy** | | | | | | | |
| Pain, function, quality of life, and outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Effects of decreasing or tapering opioid doses versus continuation of opioid therapy** | | | | | | | |
| Pain and function | 1 randomized trial (n = 10) | Very serious limitations | Unknown (1 study) | Very serious imprecision | 4 | None identified | Abrupt cessation of morphine was associated with increased pain and decreased function compared with continuation of morphine. |
| **Comparative effectiveness of different tapering protocols and strategies** | | | | | | | |
| Opioid abstinence | 2 nonrandomized trials (n = 150) | Very serious limitations | No inconsistency | Very serious imprecision | 4 | None identified | No clear differences between different methods for opioid discontinuation or tapering in likelihood of opioid abstinence after 3–6 months |
| **Risk assessment and risk mitigation strategies (KQ4)** | | | | | | | |
| **Diagnostic accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse among patients with chronic pain being considered for long-term opioid therapy** | | | | | | | |
| Opioid risk tool | 3 studies of diagnostic accuracy (n = 496)<br>New for update: 2 studies of diagnostic accuracy (n = 320) | Serious limitations | Very serious inconsistency | Serious imprecision | 4 | None identified | Based on a cutoff score of >4 (or unspecified), five studies (two fair-quality, three poor-quality) reported sensitivity that ranged from 0.20 to 0.99 and specificity that ranged from 0.16 to 0.88. |
| Screener and Opioid Assessment for Patients with Pain, Version 1 | 2 studies of diagnostic accuracy (n = 203) | Very serious limitations | No inconsistency | Serious imprecision | 3 | None identified | Based on a cutoff score of ≥8, sensitivity was 0.68 and specificity was 0.38 in one study, for a positive likelihood ratio of 1.11 and a negative likelihood ratio of 0.83. Based on a cutoff score of >6, sensitivity was 0.73 in one study. |
| Screener and Opioid Assessment for Patients with Pain-Revised | New for update: 2 studies of diagnostic accuracy (n = 320) | Very serious limitations | No inconsistency | Serious imprecision | 3 | None identified | Based on a cutoff score of >3 or unspecified, sensitivity was 0.25 and 0.53 and specificity was 0.62 and 0.73 in two studies, for likelihood ratios close to 1. |
| Brief Risk Interview | New for update: 2 studies of diagnostic accuracy (n = 320) | Very serious limitations | No inconsistency | Serious imprecision | 3 | None identified | Based on a "high risk" assessment, sensitivity was 0.73 and 0.83 and specificity was 0.43 and 0.88 in two studies, for positive likelihood ratios of 1.28 and 7.18 and negative likelihood ratios of 0.63 and 0.19. |

See table footnotes on page 47.

**TABLE 1. (*Continued*) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain**

| Outcome | Studies | Limitations | Inconsistency | Imprecision | Type of evidence | Other factors | Estimates of effect/findings |
|---|---|---|---|---|---|---|---|
| **Effectiveness of risk prediction instruments on outcomes related to overdose, addiction, abuse, or misuse in patients with chronic pain** | | | | | | | |
| Outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Effectiveness of risk mitigation strategies, including opioid management plans, patient education, urine drug screening, use of prescription drug monitoring program data, use of monitoring instruments, more frequent monitoring intervals, pill counts, and use of abuse-deterrent formulations, on outcomes related to overdose, addiction, abuse, or misuse** | | | | | | | |
| Outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Effectiveness of risk prediction instruments on outcomes related to overdose, addiction, abuse, or misuse in patients with chronic pain** | | | | | | | |
| Outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Effectiveness of risk mitigation strategies, including opioid management plans, patient education, urine drug screening, use of prescription drug monitoring program data, use of monitoring instruments, more frequent monitoring intervals, pill counts, and use of abuse-deterrent formulations, on outcomes related to overdose, addiction, abuse, or misuse** | | | | | | | |
| Outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Comparative effectiveness of treatment strategies for managing patients with addiction to prescription opioids** | | | | | | | |
| Outcomes related to abuse | None | — | — | — | Insufficient | — | No evidence |
| **Effects of opioid therapy for acute pain on long-term use (KQ5)** | | | | | | | |
| Long-term opioid use | New for update: 2 cohort studies (n = 399,852) | Serious limitations | No inconsistency | No imprecision | 3 | None identified | One study found use of opioids within 7 days of low-risk surgery associated with increased likelihood of opioid use at 1 year (adjusted OR 1.44, 95% CI = 1.39–1.50), and one study found use of opioids within 15 days of onset of low back pain among workers with a compensation claim associated with increased risk of late opioid use (adjusted OR 2.08, 95% CI = 1.55–2.78 for 1 to 140 MME/day and OR 6.14, 95% CI = 4.92–7.66 for ≥450 MME/day). |

**Abbreviations:** CI = confidence interval; ER/LA = extended release/long-acting; HR = hazard ratio; MME = morphine milligram equivalents; OR = odds ratio.
* Ratings were made per GRADE quality assessment criteria; "no limitations" indicates that limitations assessed through the GRADE method were not identified.
† Not applicable as no evidence was available for rating.

**TABLE 2. Morphine milligram equivalent (MME) doses for commonly prescribed opioids**

| Opioid | Conversion factor* |
|---|---|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1–20 mg/day | 4 |
| 21–40 mg/day | 8 |
| 41–60 mg/day | 10 |
| ≥61–80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |
| Tapentadol† | 0.4 |

**Source:** Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

* Multiply the dose for each opioid by the conversion factor to determine the dose in MMEs. For example, tablets containing hydrocodone 5 mg and acetaminophen 300 mg taken four times a day would contain a total of 20 mg of hydrocodone daily, equivalent to 20 MME daily; extended-release tablets containing oxycodone 10mg and taken twice a day would contain a total of 20mg of oxycodone daily, equivalent to 30 MME daily. The following cautions should be noted: 1) All doses are in mg/day except for fentanyl, which is mcg/hr. 2) Equianalgesic dose conversions are only estimates and cannot account for individual variability in genetics and pharmacokinetics. 3) Do not use the calculated dose in MMEs to determine the doses to use when converting opioid to another; when converting opioids the new opioid is typically dosed at substantially lower than the calculated MME dose to avoid accidental overdose due to incomplete cross-tolerance and individual variability in opioid pharmacokinetics. 4) Use particular caution with methadone dose conversions because the conversion factor increases at higher doses. 5) Use particular caution with fentanyl since it is dosed in mcg/hr instead of mg/day, and its absorption is affected by heat and other factors.

† Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.

Please note: An erratum has been published for this issue. To view the erratum, please click here.



## Steering Committee and Core Expert Group Members

***Steering Committee:*** *Deborah Dowell, MD, Tamara M. Haegerich, PhD; Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC; Roger Chou, MD; on detail to CDC under contract.*

***Core Expert Group Members:*** *Pam Archer, MPH, Oklahoma State Department of Health; Jane Ballantyne, MD; University of Washington (retired); Amy Bohnert, PhD; University of Michigan; Bonnie Burman, ScD; Ohio Department on Aging; Roger Chou, MD; on detail to CDC under contract; Phillip Coffin, MD, San Francisco Department of Public Health; Gary Franklin, MD, MPH; Washington State Department of Labor and Industries/University of Washington; Erin Krebs, MDH; Minneapolis VA Health Care System/University of Minnesota; Mitchel Mutter, MD, Tennessee Department of Health; Lewis Nelson, MD; New York University School of Medicine; Trupti Patel, MD, Arizona Department of Health Services; Christina A. Porucznik, PhD, University of Utah; Robert "Chuck" Rich, MD, FAAFP, American Academy of Family Physicians; Joanna Starrels, MD, Albert Einstein College of Medicine of Yeshiva University; Michael Steinman, MD, Society of General Internal Medicine; Thomas Tape, MD, American College of Physicians; Judith Turner, PhD, University of Washington.*

## Stakeholder Review Group

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## Opioid Guideline Workgroup

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***Workgroup Members:*** *Anne Burns, RPh; Penney Cowan; Chinazo Cunningham, MD, MS; Katherine Galluzzi, DO; Traci Green, PhD, MSC; Mitchell Katz, MD; Erin Krebs, MD, MPH; Gregory Terman, MD, PhD; Mark Wallace, MD. Workgroup Consultants: Roger Chou, MD; Edward Covington, MD; Diana Eppolito; Michael Greene, MD; Steven Stanos, DO.*

## Peer Reviewers

*Jeanmarie Perrone, MD, University of Pennsylvania; Matthew Bair, MD, Indiana University School of Medicine;, David Tauben, MD, University of Washington.*

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ISSN: 1057-5987 (Print)

# Errata

## Vol. 65, No. RR-1

In the report, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016," three errors occurred. On page 1, the last sentence of the Summary should read, "CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (**http://www.cdc.gov/drugoverdose/prescribing/resources.html**) with additional tools to guide clinicians in implementing the recommendations." On page 8, the first sentence of the first full paragraph should read, "NCIPC announced an open meeting of the NCIPC BSC in the Federal Register on January 11, **2016**." On page 49, in the fourth line of the Stakeholder Review Group, the affiliation for Gerald "Jerry" F. Joseph should read, "American College of **Obstetricians and Gynecologists**."

## Vol. 65, No. 9

In the report, "Notes from the Field: Lymphocytic Choriomeningitis Virus Meningoencephalitis from a Household Rodent Infestation — Minnesota, 2015," on page 248, the first sentence of the fourth paragraph should read, "The family was referred for integrated pest management services through **the St. Paul-Ramsey County Department of Public Health, with assistance from the Minnesota Department of Health Healthy Homes grant program**."

FDA Law Blog

Striking the Right Balance – Comprehensive Addiction and Recovery Act of 2016
By John A. Gilbert Jr. & Alan M. Kirschenbaum –

On Friday, July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act ("CARA" or "Act") of 2016, which is intended to help reverse the serious prescription drug abuse trend in the United States. Although the Act's primary objective is to address the serious problem of prescription drug abuse, CARA also includes several provisions related to pain management that reflect a recognition of the important need to treat pain. We hope that the implementation of CARA will strike the right balance between these two objectives so as to ensure a successful outcome on both fronts.

The following are some notable elements of the new law:

The Act requires the Department of Health and Human Services ("HHS") to convene a Pain Management Best Practices Inter-Agency Task Force. The goals of the Task Force are to update the best practices for pain management and prescribing pain drugs and to review medical alternatives to opioids. The Task Force is to include representatives of HHS, the Department of Defense ("DOD"), the Department of Veterans Affairs ("VA"), and the Office of National Drug Control Policy ("ONDCP") as well as practitioners, pharmacists, and other experts. The Act also requires HHS, along with other agencies, to advance education and awareness of prescription drug abuse among providers and the public. The Act identifies specific issues to be addressed, including the link between heroin and prescription opioids and the dangers of mixing fentanyl and heroin.

A significant part of the law is directed at addressing the issue of opioid abuse at VA facilities by improving the Opioid Therapy Risk Report tool and generally improving the education and training on pain management and safe opioid prescribing practices. For example, the VA is required to designate a pain management team at each facility to coordinate pain management therapy for patients.

The Act also authorizes HHS to establish a grant program to support prescribing of opioid overdose reversal drugs such as naloxone. This program would be available to Federally qualified health centers, opioid treatment programs or other practitioners authorized to dispense narcotic drugs for office based treatment. HHS is also authorized to make grants available to states to implement programs for pharmacists to dispense an FDA approved drug or device for "emergency treatment of known or suspected opioid overdose, as appropriate, pursuant to a standing order." CARA also provides for grants to states to allow first-responders to administer such drugs and for a GAO review of so-called state "Good Samaritan" laws that allow individuals to administer overdose drugs in emergency situations.

Section 705 of the Act removes a financial disincentive that currently discourages drug manufacturers from developing new abuse-deterrent formulations of pain medications. Under the Medicaid Drug Rebate Program, line extensions of existing oral dosage form innovator drugs may be subject to a higher Medicaid rebate than other newly introduced innovator drugs. The

Act amends the Medicaid Rebate statute to specifically exclude a new abuse deterrent formulation from the definition of a “line extension” that may be subject to higher rebates.

CARA also amends the federal Controlled Substances Act to allow a pharmacist to partially fill a Schedule II controlled substance prescription based on the request of the prescriber or patient. The prior law and regulations allowed a partial fill of a Schedule II drug only where the pharmacy did not have enough to dispense the entire quantity prescribed. Under the new provisions, either the prescriber or patient can request that the prescription be partially filled at first. The remainder can then be dispensed within 30 days of the original prescription. The objective of this provision appears to be an attempt to limit the amount of pain medicine received by the patient to no more than necessary. However, the new provisions will also require more diligence on the part of pharmacists to ensure that they monitor dispensing, especially if the partial filling is directed by the practitioner rather than requested by the patient. In this case, the pharmacist may need to consult with the practitioner should the patient request to fill the remainder of the prescription.

The Act also authorizes nurse practitioners and physician’s assistants to administer, prescribe, and dispense narcotics in office-based opioid treatment programs. Previously, this practice was limited to physicians. It also authorizes HHS to increase the patient limit for office-based treatment from 30 to 100.

Finally, the Act contains provisions to expand the reporting requirements and access to state prescription drug monitoring programs by practitioners as well as law enforcement. This will likely not only increase access by practitioners to assist in treating patients, but also expand the use of monitoring programs as tool for law enforcement to investigate practitioners, pharmacies, and patients.

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and Title of Person Submitting the Request: | 2) Date When Request Submitted: |
|---|---|
| Sharon Henes<br>Administrative Rules Coordinator | 26 August 2016<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |

**3) Name of Board, Committee, Council, Sections:**

Board of Nursing

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| 8 September 2016 | ☐ Yes<br>☐ No | Criteria for Approving Courses for Pharmacists Who Administer Drug Products and Devices – Consultation |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session<br>☐ Both | ☐ Yes (Fill out Board Appearance Request)<br>☐ No | |

**10) Describe the issue and action that should be addressed:**

**Pursuant to s. 450.02 (2g) (a), the Pharmacy Examining Board shall consult with the Medical Examining Board and the Board of Nursing when promulgating rules that establish criteria for approving courses under ss. 450.035 (1r) and (2) and 450.085 (1).**

**11) Authorization**

| | |
|---|---|
| *Sharon Henes* | *26 August 2016* |
| Signature of person making this request | Date |
| Supervisor (if required) | Date |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda) | Date |

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

*Revised 8/13*